SERFF Tracking Number:	*NWLC-128237251*	*State:*	*Arkansas*
Filing Company:	*Nationwide Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*GCI AO L20 000 0312*		
TOI:	*H07G Group Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07G.001 Critical Illness*
Product Name:	*Critical Illness - Forms*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Nationwide Life Insurance Company

Product Name: Critical Illness - Forms	SERFF Tr Num: NWLC-128237251	State: Arkansas
TOI: H07G Group Health - Specified Disease - Limited Benefit	SERFF Status: Closed-Approved-Closed	State Tr Num:
Sub-TOI: H07G.001 Critical Illness	Co Tr Num: GCI AO L20 000 0312	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Authors: LaToyia Brooks, Andrea Roberts	Disposition Date: 05/09/2012
	Date Submitted: 04/27/2012	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments: Concurrently, being filed in Nationwide's state of domicile Ohio.
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Group Market Type: Employer, Association	Overall Rate Impact:
Filing Status Changed: 05/09/2012	
State Status Changed: 05/09/2012	Deemer Date:
Created By: LaToyia Brooks	Submitted By: Andrea Roberts

Corresponding Filing Tracking Number:

Filing Description:

Nationwide Life Insurance Company is filing a Group Health Specified Disease Limited Benefit – Critical Illness filing for general use and approval by the Department of Insurance. Upon approval by the Department, Nationwide will begin utilizing these forms. No part of the filing contains any unusual or possibly controversial items from normal company or industry standards.

Description of Filing

SERFF Tracking Number:	*NWLC-128237251*	*State:*	*Arkansas*
Filing Company:	*Nationwide Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*GCI AO L20 000 0312*		
TOI:	*H07G Group Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07G.001 Critical Illness*
Product Name:	*Critical Illness - Forms*		
Project Name/Number:	*/*		

Attached are the Policy, Certificate, Schedule of Benefits, Application and Evidence of Insurability. These forms are new and do not replace any existing forms.
Additionally, the below previously approved forms will be used in conjunction with the above forms.
Amendment – NSHGEN 2400 approved on 11/4/2011; SERFF Tracking #NWLC-127783060
Throughout the policy forms, and specifically the schedule of benefits, you will see bracketing. Numerical ranges are included in the schedule of benefits. In order to assist you with your review, we are including an explanation of variables.

Your prompt attention to this submission will be appreciated. If there are any questions, please do not hesitate to contact me.
State Narrative:

Company and Contact

Filing Contact Information

Andrea Roberts, Sr. Compliance Analyst	roberta8@nationwide.com
1 Nationwide Plaza	614-677-8010 [Phone]
1-32-101	
Columbus, OH 43215	

Filing Company Information

Nationwide Life Insurance Company	CoCode: 66869	State of Domicile: Ohio
5525 Parkcenter Circle	Group Code: 140	Company Type:
Dublin, OH 43017	Group Name:	State ID Number:
(614) 854-3375 ext. [Phone]	FEIN Number: 31-4156830	

Filing Fees

Fee Required?	Yes
Fee Amount:	$350.00
Retaliatory?	No
Fee Explanation:	7 forms at $50.00 per form
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Nationwide Life Insurance Company	$350.00	04/27/2012	58692863

SERFF Tracking Number:	*NWLC-128237251*	*State:*	*Arkansas*
Filing Company:	*Nationwide Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*GCI AO L20 000 0312*		
TOI:	*H07G Group Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07G.001 Critical Illness*
Product Name:	*Critical Illness - Forms*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/09/2012	05/09/2012

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	05/01/2012	05/01/2012	Andrea Roberts	05/08/2012	05/08/2012

SERFF Tracking Number:	*NWLC-128237251*	*State:*	*Arkansas*
Filing Company:	*Nationwide Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*GCI AO L20 000 0312*		
TOI:	*H07G Group Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07G.001 Critical Illness*
Product Name:	*Critical Illness - Forms*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 05/09/2012
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*NWLC-128237251*	*State:*	*Arkansas*
Filing Company:	*Nationwide Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*GCI AO L20 000 0312*		
TOI:	*H07G Group Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07G.001 Critical Illness*
Product Name:	*Critical Illness - Forms*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Form	Policy	Approved-Closed	Yes
Form	Certificate	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	NEB Application	Approved-Closed	Yes
Form	Assoc. Application	Approved-Closed	Yes
Form	Evidence of Insurability	Approved-Closed	Yes
Form *(revised)*	Endorsement	Approved-Closed	Yes
Form	Endorsement	Replaced	Yes

SERFF Tracking Number:	*NWLC-128237251*	*State:*	*Arkansas*
Filing Company:	*Nationwide Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*GCI AO L20 000 0312*		
TOI:	*H07G Group Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07G.001 Critical Illness*
Product Name:	*Critical Illness - Forms*		
Project Name/Number:	*/*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	05/01/2012
Submitted Date	05/01/2012
Respond By Date	

Dear Andrea Roberts,

This will acknowledge receipt of the captioned filing.

Objection 1

- Certificate, GCI AO L25 000 0312 (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number:	*NWLC-128237251*	*State:*	*Arkansas*
Filing Company:	*Nationwide Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*GCI AO L20 000 0312*		
TOI:	*H07G Group Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07G.001 Critical Illness*
Product Name:	*Critical Illness - Forms*		
Project Name/Number:	*/*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	05/08/2012
Submitted Date	05/08/2012

Dear Rosalind Minor,

Comments:

Response 1

Comments: Provision has been revised for your review.

Related Objection 1

Applies To:

- Certificate, GCI AO L25 000 0312 (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Endorsement	GCI AR L24 000 0312		Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		0.000	AR State Endorsement.pdf
Previous Version							
Endorsement	*GCI AR L24 000*		*Policy/Contract/Fraternal Certificate: Amendment,*	*Initial*		*0.000*	AR State Endorsem

SERFF Tracking Number:	*NWLC-128237251*	*State:*	*Arkansas*
Filing Company:	*Nationwide Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*GCI AO L20 000 0312*		
TOI:	*H07G Group Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07G.001 Critical Illness*
Product Name:	*Critical Illness - Forms*		
Project Name/Number:	*/*		

0312	*Insert Page, Endorsement or Rider*	ent.pdf

No Rate/Rule Schedule items changed.

Sincerely,
Andrea Roberts, LaToyia Brooks

SERFF Tracking Number:	*NWLC-128237251*	*State:*	*Arkansas*
Filing Company:	*Nationwide Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*GCI AO L20 000 0312*		
TOI:	*H07G Group Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07G.001 Critical Illness*
Product Name:	*Critical Illness - Forms*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: GCI AO L20 000 0312

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 05/09/2012	GCI AO L20 000 0312	Policy/Contract/Fraternal Certificate	Policy	Initial		58.000	Critical Illness Policy.pdf
Approved-Closed 05/09/2012	GCI AO L25 000 0312	Certificate	Certificate	Initial		52.400	Critical Illness Certificate.pdf
Approved-Closed 05/09/2012	GCI AO L26 000 0312	Data/Declaration Pages	Schedule of Benefits	Initial		0.000	Critical Illness SCHEDULE.pdf
Approved-Closed 05/09/2012	GGEN AO L23 000 0312	Application/Enrollment Form	NEB Application	Initial		0.000	GGEN AO L23 000 0312_Group App_.pdf
Approved-Closed 05/09/2012	AGEN AO L23 000 0312	Application/Enrollment Form	Assoc. Application	Initial		0.000	AGEN AO L23 000 0312_Assoc app_.pdf
Approved-Closed 05/09/2012	GGEN AO L30 000 0412	Application/Enrollment Form	Evidence of Insurability	Initial		0.000	GGEN AO L30 000 0412_E of I form_.pdf
Approved-Closed 05/09/2012	GCI AR L24 000 0312	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorseme	Endorsement	Initial		0.000	AR State Endorsement.pdf

SERFF Tracking Number:	*NWLC-128237251*	*State:*	*Arkansas*
Filing Company:	*Nationwide Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*GCI AO L20 000 0312*		
TOI:	*H07G Group Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07G.001 Critical Illness*
Product Name:	*Critical Illness - Forms*		
Project Name/Number:	*/*		

nt or Rider

Nationwide Life Insurance Company
Home Office: One Nationwide Plaza, Columbus, Ohio 43216
(Hereafter called We, Us or Our in this Policy)
[Administrative Office:]

GROUP CRITICAL ILLNESS/SPECIFIED DISEASE POLICY

Policyholder:	[JOHN DOE CO.]
Policy Effective Date:	[January 1, 2012]
Policy Number:	[000000]
[Policyholder Address:	[Address]]
[Associated Companies:]	
[First Policy Anniversary:	[July 1, 2013]]
[Subsequent Policy Anniversaries:	Each [July 1]]
[Initial Term:	[1-24 Months in one month increments]]
Premium Due Dates:	[dates will reflect mode - Weekly, Bi-weekly, Monthly, Quarterly, Semi-annually, Annually, or coincident with the payroll cycle]
State or Other Jurisdiction of Issue:	[Any State]

We agree to insure the Eligible Persons described in the Eligible Classes section shown in the Schedule of Benefits. We will do this while this Policy stays in force. We agree to pay the benefits of this Policy to the persons insured. Details of the benefits are shown in the certificates attached to this Policy. These certificates form a part of this Policy.

Premiums
The Policyholder has applied for this Policy and understands that the required premium must be paid to get the insurance and keep it in force.

When This Policy Will Take Effect
This Policy will take effect at 12:01 A.M. standard time at the Policyholder's address on the Effective Date above, its date of issue.

We witness that this Policy is executed on its date of issue at Columbus, Ohio.

Signed for Nationwide Life Insurance Company

[ ] [ ]

Secretary President

Non-Participating Insurance which can be terminated by Us as described in the Policy.
THIS POLICY IS A LEGAL CONTRACT BETWEEN YOU AND US.

THIS POLICY PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED TO COVER ALL MEDICAL EXPENSES.
READ THE POLICY CAREFULLY.

GENERAL PROVISIONS APPLICABLE TO ALL BENEFITS

Agency
The Policyholder and any administrator appointed by the Policyholder shall not be considered Our agents for any purpose. We are not liable for any of their acts or omissions.

Entire Contract
The entire contract consists of:

1. this Policy;
2. the Certificate;
3. any Riders, Endorsements and Amendments, if any, adding or changing the provisions of the Policy or Certificate;
4. the Application of the Policyholder;
5. Evidence of Insurability Form.

A copy of the Policyholder's Application is attached to this Policy on the date it is signed. All statements made in the Application and Evidence of Insurability Form, in the absence of fraud, are representations and not warranties. No statement made by an Insured Person under this Policy will be used to void insurance or deny a claim unless a copy of the statement is or has been given to that Insured Person.

Individual Certificate
We will make a certificate available to each Insured Person under this Policy. Certificates will state the insurance protection to which a Covered Person is entitled and to whom the benefits are payable.

Conformity with State Laws
The insurance laws of some states require that certain Policy provisions comply with the law of the state for all permanent residents of the state. Any Policy provision herein which does not conform with such law is hereby modified to the minimum extent necessary to satisfy legal requirements.

Misstatements
If any relevant fact as to a Covered Person to whom this insurance relates is found to have been misstated, the true facts will be used to determine whether His/Her insurance is in force under the Policy and in what amount. If the error has an effect on the Premium, an adjustment of the Premium due will be made.

Non-Participating
This Policy is non-participating. This means that the Policyholder does not share in Our surplus earnings.

Assignment
No assignment of this Policy is binding upon Us unless We agree to it in writing and not until it is filed with Us.

Incontestability
The Policy will be incontestable, except for non-payment of premium and material fraudulent misstatements, after it has been in force for two years.

Clerical Error
Any clerical error by Us in keeping relevant records, or a delay in making any entry, will not void any insurance otherwise validly in force or continue insurance otherwise validly terminated. When a clerical error or delay is found, Premiums and benefits will be adjusted based on the true facts and the provisions of the Policy.

Changes In Policy
The terms of this Policy can be changed only by written agreement between the Policyholder and Us. Agreement for Us can only be made by Our President or Our Corporate Secretary. Any changes will be made without the consent of, or notice to, any Insured Person. No agent has authority to contract directly with Us for this Policy or to change, alter or amend any of its terms or provisions in any way.

Policyholder Required Information
Certain facts are needed to administer the Policy. We have the right to decide which facts We need. The Policyholder is required to comply with any reasonable request for information which We deem necessary to administer the Policy. We have the right to inspect any records of the Policyholder that have a bearing on the insurance or Premium under the Policy.

Incorporation Provision
The provisions of the attached Certificate of Insurance, any Rider(s), and any Endorsement(s), including any Rider or Endorsement added after the Group Critical Illness/Specified Disease Policy. The Certificate(s) and Rider(s) attached to this Policy will control each Covered Person's coverage eligibility, effective date, termination date, benefits, limitations and exclusions.

New Entrants
New persons to the groups or classes eligible for insurance must be added to the groups or classes for which they are eligible.

[Workers' Compensation Not Affected
This Policy does not replace or change any requirement for coverage under Workers' Compensation insurance.]

PREMIUM PROVISIONS

[Payment of Premiums {Employer}
The Premiums due under this Policy are payable in advance directly to Us. The first Premium is due on the Effective Date of this Policy. Premiums after the first are due on the Premium Due Date shown on the cover page of this Policy. The payment of any Premium will not maintain the insurance in force beyond the day next following the Premium Due Date, except as provided under the Grace Period provision.]

[Payment of Premiums {Association}
Premiums are payable monthly and agreed to by Us. Premiums must be paid to Us at Our Home Office or to Our Agent. The payment of any Premium will keep the Coverage under the Policy in force to the next Premium due date, subject to the Grace Period provision.]

Premium Adjustments
When additional or increased insurance begins or ends and the change is due to a change in the terms of this Policy, any adjustment in the Premium will be made as of the date the change is effective. Otherwise, any adjustment in Premium will be made on the Premium Due Date which occurs on or next follows the date of change (or the first day of the calendar month which occurs on or next follows the date of change if Premiums are payable other than monthly).

Changes in Premium Rates
We have the right to change the Premium rates on any Premium Due Date after the Initial Term. After the Initial Term, We will not increase the Premium rates more than once in any [1, 3, 6, 9, 12] month period. We will notify the Policyholder in writing at least [30, 31, 45, 60, 90] days in advance of any increase.

The Initial Term starts on the Policy Effective Date and runs for the number of months shown above.

[Premium Rate Guarantees
Any Premium rate guarantees are subject to the following provisions:
1. The benefits outlined in the Certificate as well as the eligibility remain unchanged;
2. There are no additions or deletions of subsidiaries or affiliates;
3. The census or geographic distribution does not change by more than [5-50%,in 5% increments];
4. The employer contribution, if applicable, to the Premium is not reduced.]

[Policyholder Grace Period A Grace Period of [31-90] days (without interest charge) is granted for the payment of any Premium Due Date after the first. This Policy will continue in effect during this period unless the Policyholder has given written notice to Us that the insurance under this Policy is to be ended on the first day before the Grace Period would otherwise start. If the Premium is not paid by the end of the Grace Period all insurance under this Policy will end on the

last day of the Grace Period, and the Policyholder will owe Us all Premiums then due and unpaid including the Premium for the Grace Period.

If the Policyholder gives Us written notice that insurance under this Policy is to be ended during the Grace Period, all insurance will end on the date We receive the written notice or the date specified, if later. The Policyholder will owe Us the pro-rata Premium for the time the insurance was in effect during the Grace Period.]

TERMINATION OF INSURANCE

The Policy will continue for as long as Premiums are paid or until it is terminated or cancelled. Notice to cancel or terminate the Policy may come from either the Policyholder or from Us. The Policyholder may cancel any or all of the insurance by giving Us written notice. It will terminate on the later of:

1. the date requested in the cancellation notice; or
2. the date We receive the notice.

We may terminate insurance as of a Premium due date with a [31, 45, 60, 90 day] advance notice in writing to the Policyholder. However, prior to the first Policy anniversary, We may only terminate insurance if :

1. the Policyholder does not perform its duties under the Policy to Our satisfaction[; or]
2. [the Policyholder is paying the full cost of the coverage and less than 100% of the employees eligible for coverage are participating in the plan; or]
3. [the employees are paying some of the cost of their coverage and less than [25%-100%] of the employees eligible for coverage are participating in a plan; or]
4. [the employees are paying all of the cost of their coverage and less than [10%-100%] of the employees eligible for coverage are participating in a plan; or]
5. [fewer than [5-50] employees are insured for coverage under this policy or plan; or]
6. [the Policyholder ceases to sponsor coverage under the Policy, or sponsors the same or similar coverage through another arrangement without Our written agreement.]

In either event, Premium is due and payable through the date on which coverage under the Policy terminates. If the Premium is not paid, the Policy will terminate as of the last day for which Premium was paid [subject to the Grace Period Provision above].

Insurance will end as provided above without the consent of, or notice to, any Covered Person, unless otherwise required by state law.

Nationwide Life Insurance Company

CERTIFICATE OF COVERAGE FOR CRITICAL ILLNESS/SPECIFIED DISEASE

Home Office: One Nationwide Plaza, Columbus, Ohio 43216
(Hereafter called We, Us or Our in this Policy)
[Administrative Office:]

INSURING AGREEMENT

The Nationwide Life Insurance Company has issued a Policy covering certain Eligible Classes of the Policyholder.

The Benefits of the Policy are described in this Certificate and Your Schedule of Benefits.

Final interpretation is governed by the Policy. You may review the Policy at the Policyholder's address during normal business hours. This Certificate replaces any and all Certificates previously issued for the Eligible Classes under the Policy. This Certificate describes the Policy in detail.

NOTICE CONCERNING YOUR CERTIFICATE

IMPORTANT NOTICE: Benefits are payable only for losses incurred while a Covered Person's insurance is in force and after any applicable Benefit Waiting Periods have been served. The applicable Benefit Waiting Period is shown in the Schedule of Benefits.

The Policy under which the Certificate is issued may at any time be amended or canceled, as stated in its provisions. Such an action may be taken without the consent of or notice to any Covered Person who claims rights or Benefits under the Policy.

Signed for Nationwide Life Insurance Company

President

Secretary]

NON-PARTICIPATING

THIS CERTIFICATE PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

PLEASE READ YOUR CERTIFICATE CAREFULLY. KEEP IT IN A SAFE PLACE.
[CONTRIBUTORY][NON-CONTRIBUTORY][VOLUNTARY]

TABLE OF CONTENTS

GENERAL DEFINITIONS

Accident or Accidental or Accidental Injury or Injury: A specific unforeseen event, that is:

1. sudden, unexpected, and unintended, over which a Covered Person has no control and which happens while the Covered Person is covered under the Policy;
2. which directly, and from no other cause, results in an Injury; and
3. is independent from sickness, disease, bodily infirmity, or Illness.

[**Activity(ies) of Daily Living (ADLs):** Certain basic daily tasks necessary to maintain a person's health and safety. In this Policy, ADLs refer to the activities described below. [The loss of ability must be due to a Critical Illness.]

1. Transfer and mobility - The ability to move into or out of a bed, chair or wheelchair or to move from place to place, either via walking, a wheelchair, cane, crutches, walker or other equipment.
2. Continence - The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter, urostomy, or colostomy bag).
3. Dressing - Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
4. Toileting - Getting to and from the toilet, transferring on and off the toilet and performing associated personal hygiene.
5. Eating - Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
6. Bathing - Washing oneself by sponge bath; or in either a tub or a shower, including the task of getting into or out of the tub or shower.]

[Active Work/Actively at Work: [You are performing the normal duties of Your regular occupation and working Your normal hours. [You must be working [at least the number of] [a minimum of [1-40]] hours per week as defined by the Policyholder on a [permanent] [Full–Time] [Part-Time] basis and must be paid regular earnings.]
Your work site must be:

1. at the Policyholder's usual place of business; or
2. at a location to which the Policyholder's business requires You to travel.

You are not considered Actively at Work when You are off work or lose time due to Illness, Injury, Leave of Absence, strike or lay-off. Paid days off will count as Actively at Work if You were fully capable of performing the normal duties of Your regular occupation during the paid days off, provided that You were Actively at Work on the last working day prior to the paid days off.] ~*or*~

[As defined by the Policyholder and Us.]]

[**Active Insured Person:** An Actively at Work Insured Person of the Policyholder according to such Policyholder.]

[Advanced Parkinson's Disease: The Diagnosis, by a Doctor board-certified as a neurologist, of Parkinson's Disease staged at 3 or more on the Hoehn and Yahr staging scale or an equivalent stage on a different scale. No other degenerative brain disorders, including atypical parkinsonian syndromes or psychiatric illnesses shall meet the definition of Advanced Parkinson's Disease, nor will they be considered a Critical Illness.]

Age: Age at last birthday.

[Advanced Alzheimer's Disease: The Diagnosis, by a Doctor board-certified as a neurologist, of Advanced Alzheimer's Disease. The Covered Person must exhibit loss of intellectual capacity involving impairment of memory and judgment as measured by clinical evidence and standardized testing. It must result in significant reduction in mental and social functioning such that the Covered Person requires Substantial Assistance in performing at least [two, three] of the six Activities of Daily Living. No other dementing brain disorders or psychiatric Illnesses shall meet the definition of Advanced Alzheimer's Disease, nor will they be considered a Critical Illness.]

Amendment: A document that modifies the Policy and becomes part of the Policy.

[Angioplasty: The actual undergoing of a percutaneous transluminal angioplasty ordered by a Doctor to correct a narrowing or blockage of one or more coronary arteries. A Doctor board-certified as a cardiologist must perform the Procedure. Other surgical or non-surgical techniques such as laser relief or any other intra-arterial procedures are excluded.]

[Aortic Surgery: The actual undergoing of surgery for disease of the aorta needing excision and surgical replacement of a portion of the diseased aorta with a graft. The surgery must be ordered by and performed by a Doctor, board-certified as a cardiovascular surgeon, thoracic surgeon, or vascular surgeon. Aorta is limited to the thoracic and abdominal aorta, but not its branches.]

Benefit Amount: The total Benefit for a Covered Person on which the percent of Benefit is payable for a Diagnosis of a Critical Illness or Procedure related to a Critical Illness. The Benefit Amount is shown in the Schedule of Benefits.

Benefit: The dollar amount payable by Us to a claimant or assignee under the Policy.

Benefit Waiting Period: The number of days shown in the Schedule of Benefits immediately following each Covered Person's Effective Date of Coverage [or Request for an increase in coverage].

[Blindness: The diagnosis, by a Doctor board-certified as an ophthalmologist, of the permanent and uncorrectable loss of sight in both eyes. The Covered Person's corrected visual acuity must either be worse than 20/200 in both eyes or the field of vision must be less than 20 degrees in both eyes. [Blindness does not include any Covered Person who has not attained Age [2, 3, 4, 5] on the date of Diagnosis.]]

[Calendar Year: For the first year is the period of time that begins on the Effective Date and ends on December 31st. For subsequent years, it is the period of time that begins on January 1st and ends December 31st.]

[Cancer in Situ: a Diagnosis of cancer where the tumor cells lie within the tissue of origin without having invaded neighboring tissue. Cancer in Situ includes early prostate cancer diagnosed as T1N0M0 or equivalent staging and melanoma not invading the dermis. It does not include:

1. Other skin malignancies;
2. Pre-malignant lesions such as intraepithelial neoplasia;
3. Benign tumors or polyps.

In Situ Cancer must be diagnosed pursuant to a Pathological Diagnosis or Clinical Diagnosis.]

Certificate: This document which provides a description of the Coverage available under the Policy.

[Child or Children: See definition of Eligible Dependent.]

Claim: A request for payment of covered Benefits.

Claimant: A person who has filed a claim for Benefits under the Policy, as a Covered Person.

[Clinical Diagnosis of Invasive Cancer: a Diagnosis of Invasive Cancer or In Situ Cancer based on the study of symptoms and diagnostic test results. We will accept a Clinical Diagnosis only if the following conditions are met:

1. A Pathological Diagnosis cannot be made because it is medically inappropriate or life threatening;
2. There is medical evidence to support the Diagnosis; and
3. A Doctor is treating the Covered Person for Invasive Cancer or In Situ Cancer.]

[Coma: The Diagnosis by a Doctor board-certified as a neurologist that a Covered Person is in a state of unconsciousness from which he or she cannot be aroused, in which external stimulation will produce no more than primitive avoidance reflexes, and that this state has persisted continuously for at least [96-120] hours. Coma does not include a temporary induced coma for medical treatment]

[Contributory: You pay a portion of the Premium for Coverage.]

[Coronary Artery By-Pass Graft: The actual undergoing of Coronary Artery Bypass Surgery using either a saphenous vein or internal mammary artery graft for the treatment of coronary heart disease deemed medically necessary to correct a narrowing or blockage of one or more coronary arteries. The Procedure must be performed by a Doctor board-certified as a cardiologist. Other surgical or non-surgical techniques such as laser relief or any other intra-arterial procedures are excluded.]

Coverage: The right of the Covered Person to receive Benefits subject to the terms, conditions, limitations, and exclusions of the Policy.

Covered Person: You [and Your Eligible Dependents, if applicable,] whom You have enrolled for insurance and paid any Premium due under the Policy.

Critical Illness: Covered Critical Illnesses as listed in the Schedule of Benefits.

Date of Diagnosis or **Procedure:** The date the Diagnosis is established by a Doctor through the use of clinical and/or laboratory findings as supported by the Covered Person's medical records. For a Procedure, it is the date the Covered Person undergoes the Procedure.

[**Dependent or Covered Dependent**: Your Eligible Dependent who is insured under the Policy.]

Diagnosis: The definitive establishment of the Critical Illness, as defined herein, using clinical and/or laboratory findings. The Diagnosis must be made by a Doctor who is a board certified specialist and qualified to make the Diagnosis.

Doctor: A person who is:

1. Licensed as a provider of medical services by the state in which the provider practices.
2. Acting within the scope of his or her license and a board certified specialist where required under the Policy.
3. Legally qualified to diagnose and treat a Critical Illness.
4. Not one of the following:
   - A person who ordinarily resides in Your household
   - An Immediate Family Member or a business partner
   - The Policyholder.

[Domestic Partner: An individual in a relationship with You that satisfies the following criteria:

1. For at least [6-12] consecutive months prior to Your Domestic Partner's Effective Date of Insurance, You and Your Domestic Partner, are and have been each other's sole Domestic Partner and have maintained the same principal place of residence; and
2. Your Domestic Partner is at least 18 years of age; and
3. You and Your Domestic Partner are not married or related by blood; and
4. You and Your Domestic Partner are jointly responsible for each other's welfare and financial obligations; and
5. You and Your Domestic Partner are not legally married to anyone else.]

Effective Date: The date on which insurance Coverage begins under the Policy.

[Eligibility Waiting Period: The continuous length of time a Person must serve in an Eligible Class to reach his or her eligibility date and begin his or her Coverage [and his or her Eligible Dependent Coverage.] [The Eligibility Waiting Period is shown in the Schedule of Benefits.]]

Eligible Class: A group of people who are eligible for Coverage under the Policy. See the Schedule of Benefits for a list of Eligible Classes. [Each person of the Eligible Class will qualify for insurance on the date he or she completes the required Eligibility Waiting Period].

[**Eligible Dependent**: Includes:

1. Your Spouse (if not legally separated or divorced from You)[; or][; and]
2. [Your Domestic Partner]; and
3. Your or Your [Spouse's] [or Domestic Partner's] [unwed] Child from the moment of birth, until the Child attains age [19-30][; and]
4. [Your [unwed] Child who is a student may be covered until attaining age [26-30] provided such Child is a Full Time Student and more than 50% dependent up on You for support and maintenance. Proof of the Child's enrollment as a Full time Student must be submitted to Us upon request].

Children include natural children, stepchildren, adopted children, [grandchildren,] children Placed for Adoption, children appointed to Your custody by a court order, or foster children who are dependent upon You for support. Adopted children include a child where an Eligible Person has the assumption and retention of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. Such child is no longer considered an Eligible Dependent upon the termination of that legal obligation.

The term Eligible Dependent does not include any person who:

1. Is in full-time active duty in the armed forces of any country or international authority; or

2. Lives outside of the United States [or Canada][or Mexico]; or
3. Is an Insured Person under the Policy.]

Eligible Person: A person who belongs to an Eligible Class as described in the Schedule of Benefits [and is a citizen or permanent resident of the United State [or Canada [or] Mexico]].

[End Stage Renal Failure: Chronic irreversible failure of both kidneys to function, as a result of which either regular renal or peritoneal dialysis is started, or renal transplant is required. The Diagnosis must be made or the Procedure recommended by a board-certified nephrologist.]

Enrollment Form: The document completed by You in electing Coverage under the Policyholder's Policy. The document may be written or electronic on a form that is furnished or approved by Us.

[Enrollment Period: A period of time agreed to by the Policyholder and Us during which either: 1) an Eligible Person may enroll for insurance under the Critical Illness Policy if he or she did not enroll when initially eligible or 2) if a Covered Person is currently enrolled he or she wants to, [increase, decrease, or terminate] his or her insurance].

[First Occurrence: Subject to any Pre-existing Condition limitation period, the first time that a Diagnosis is made for or a Procedure is recommended for a Critical Illness while a Covered Person is covered under the Policy. A Diagnosis made or Procedure recommended for a Critical Illness after satisfaction of the Pre-existing Condition limitation period is considered a First Occurrence.]

[Full-time: A regular work week as defined by the Policyholder. We have the right to verify the hours worked by reviewing payroll records and/or income tax statements.]

Group: The Policyholder or entity who has entered into a contract with Us to provide Coverage under the Policy.

[Heart Attack (Myocardial Infarction): Ischemic death of a portion of the heart muscle due to a blockage of one or more coronary arteries and resulting in the loss of the normal function of the heart. The Diagnosis must be made by a Doctor board-certified as a cardiologist and must be based on both:

1. New clinical presentation and electrocardiographic changes consistent with an evolving Heart Attack; and
2. Serial measurement of cardiac biomarkers showing a pattern and to a level consistent with a Diagnosis of Heart Attack.

This Benefit does not cover an established (old) myocardial infarction.]

[Heart Transplant: The clinical evidence of heart failure which requires the malfunctioning heart of the Covered Person to be replaced with the heart from a suitable human donor (excluding the Covered Person) under generally accepted medical procedures. A Covered Person will be eligible for benefit payment for a Heart Transplant on the date he is registered and accepted by the United Network of Organ Sharing (UNOS).]

[Heart Valve Replacement/Repair Surgery: The actual undergoing of open heart surgery to replace or repair one or more valves. The surgery must be ordered by and performed by a Doctor , board-certified as a cardiovascular surgeon or thoracic surgeon.]

[Hospital: An institution that:

1. Operates pursuant to law; and
2. Has 24 hour nursing services by registered nurses; and
3. Has a staff of one or more Doctors; and
4. Provides inpatient therapeutic and diagnostic services for Injury or Illness; and
5. Provides facilities for major surgery or has a formal arrangement with another institution for surgical facilities; and
6. Is approved by the Joint Commission on the Accreditation of Health Care Facilities as a Hospital (JCAHO); or
7. Is approved by the American Hospital Association (AHA); or
8. Is approved by the American Osteopathic Healthcare Association (AOHA); or
9. Is approved by the American Osteopathic Association accreditation (AOA); or
10. Is approved by the Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation.

Unless otherwise provided in the Policy, Hospital does not include any of the following:

1. A rest or nursing home, home for the aged or convalescent home; or
2. A Skilled Nursing Facility; an extended care facility; or

3. A hospice or a place for custodial care, birthing center.]

[**Illness**: A sickness, disease or condition that impairs a Covered Person's normal functioning of mind or body and which is not the direct result of an Accidental Injury.]

Immediate Family Member: Your Spouse [or Domestic Partner] and Your or Your Spouse's [or Domestic Partner's] children, brothers, sisters, uncles, aunts, in-laws, grandparents, and parents.]

[Initial Enrollment Period: The period of time determined by the Policyholder during which an Eligible Person may first enroll for insurance under the Policy. The number of days is shown in the Schedule of Benefits.]

[Inpatient: Confinement in a Hospital or Skilled Nursing Facility for which a room and board charge is made.]

Insured Person: A person who is an Eligible Person, [who has qualified for insurance by completing any Eligibility Waiting Period, paying any Premium due, and] for whom insurance under the Policy has become effective.

[Intensive Care Unit: A Hospital unit, including a coronary care unit, in which patients are grouped in an area where:
1. facilities and staff are tailored to the special needs of the seriously ill;
2. 24 hour per day care by registered nurses is provided; and
3. life saving drugs and equipment are always at hand.

Such units must render care more intensive than that rendered in the general surgical or medical nursing units which treat most of the Hospital's Inpatients.]

[Invasive Cancer: A malignant neoplasm, which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue, and which is not specifically hereafter excluded. Leukemia and lymphomas are included. The following are not considered Invasive Cancer
1. pre-malignant lesions (such as intraepithelial neoplasia); or
2. benign tumors or polyps; or
3. early prostate cancer diagnosed as T1N0M0 or equivalent staging; or
4. In Situ Cancer; or
5. any skin cancer (other than invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic).

Invasive Cancer must be diagnosed according to a Pathological Diagnosis or Clinical Diagnosis.]

[Leave of Absence: An arrangement where You and the Policyholder agree that You will not be Actively at Work for a specified period of time and You are expected to be Actively at Work at the end of that period. Refer to "When Your Coverage Begins and Ends" section to determine how long Your Coverage can be continued during a Leave of Absence.]

[Loss of Independent Living: The Covered Person cannot perform [two][three] Activities of Daily Living for a continuous period of [30-365] days.]

[Loss of Limb: Dismemberment due to the actual, complete, and permanent severance through or above the wrist or ankle joint.]

[Major Organ Transplant: The clinical evidence of major organ(s) failure which requires the malfunctioning organ(s) or tissue of the Covered Person to be replaced with an organ(s) or tissue from a suitable human donor (excluding the Covered Person) under generally accepted medical procedures. The organs and tissues covered by this definition are limited to: liver, [kidney,] lung, small intestine, pancreas, pancreas-kidney or bone marrow. In order for the Major Organ Transplant to be covered under this Policy, the Insured must be registered by the United Network of Organ Sharing (UNOS) or the National Marrow Donor Program (NMDP).]

[Motor Neuron Disease – An unequivocal Diagnosis of one of the following motor neuron diseases: amyotrophic lateral sclerosis (A.L.S. or Lou Gehrig's Disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy. Coverage is limited to these conditions and all other variations of motor neuron disease are excluded. The Diagnosis must be made by a Doctor, board-certified neurologist.]

[**Non-Contributory:** You pay no portion of the Premium for Coverage.]

[Occupational Human Immunodeficiency Virus (HIV): Diagnosis of infection with the Human Immunodeficiency Virus

(HIV) resulting from an Accidental Injury which occurred in the United States after the issue date of the policy, and which exposed the Covered Person to HIV-contaminated blood or bodily fluids during the course of the duties of his or her normal occupation. Payment under this condition requires satisfaction of ALL of the following:

1. The Accidental Injury must be reported to Us within 14 days of the Accidental Injury;
2. An HIV test must be taken within 14 days of the Accidental Injury and the result must be negative;
3. An HIV test must be taken between 90 days and 180 days after the Accidental Injury and the result must be positive; and
4. The Accidental Injury must have been reported, investigated and documented in accordance with workplace legislation and regulations.

Occupational HIV excludes HIV Infection as a result of drug use or sexual transmission.]

[Paralysis: The complete and permanent loss of function of [one, two] or more limbs through neurological Injury for a period of at least [90,180] days as confirmed by a Doctor board certified as a neurologist.]

[Part-Time: A schedule of work defined as part-time by the Policyholder. We have the right to verify the hours worked by reviewing payroll records and/or income tax records.]

[Pathological Diagnosis: A Diagnosis of Invasive Cancer or In Situ Cancer based on a microscopic study of fixed tissue or preparations from the blood systems. This type of Diagnosis must be done by a Doctor who is a board certified pathologist and whose Diagnosis of Invasive Cancer or In Situ Cancer conforms to the standards set by the American College of Pathology.]

[**Period of Confinement:** An interval of time during which a Covered Person is confined as an Inpatient in a Hospital or Skilled Nursing Facility due to a Critical Illness. A covered Period of Confinement begins on the date the Covered Person is admitted to the Hospital or Skilled Nursing Facility. Successive Periods of Confinement:

1. due to the same Critical Illness and
2. separated by less than [30,60,90,180] days;

are part of the same Period of Confinement.

A new covered Period of Confinement begins when the Covered Person is readmitted to a Hospital or Skilled Nursing Facility:

1. due to the same Critical Illness; and
2. after he or she has been free of Hospital or Skilled Nursing Confinement for [30, 60, 90, 180] days or more.]

[Placement for Adoption; Placed for Adoption; Placement: A Child is placed in Your physical custody for the purpose of adoption.]

Plan Year: The period of time shown in the Schedule of Benefits as Calendar Year or Policy Year.

Policy: The agreement between Us and the Policyholder which states the terms, conditions, limitations, and the exclusions regarding Coverage.

[Policy Anniversary: The month and day as shown on the Schedule of Benefits as the Policy Anniversary.]

[Policy Year: For the first year is the period of time that begins on the Policy Effective Date and ends on the day before the next following Policy Anniversary. For subsequent years, it is the period of time that begins on the first and each subsequent Policy Anniversary and ends on the day before the next Policy Anniversary.]

Policyholder: The organization named in the Schedule of Benefits who has contracted with Us to provide Benefits to You.

Premium: The periodic fee required to maintain Coverage for each Covered Person in accordance with the terms of the Policy.

[Prior Plan: The Critical Illness Policy that was in effect with the Policyholder for a different insurance company on the date immediately preceding the effective date under this Policy.]

Procedure: A medical Procedure involving an incision with instruments and performed to repair damage or arrest disease related to a Critical Illness in a Covered Person.

Proof: Evidence satisfactory to Us that the terms and provisions of the Policy have been met. Proof may include but is not limited to: questionnaires, physical exams, or written documentation and records as required by Us. Proof must be received by Us at Our [Home Office] [Administrative Office]. All Proof must be given at Your expense (or that of Your representative), unless otherwise specifically provided by the terms of the Policy. If any additional Proof is reasonably required by Us, a Covered Person may be required to give Us authorization to obtain such additional Proof.

The following is a specific type of Proof referenced under the Policy:

Proof of Loss: Evidence satisfactory to Us that a person has satisfied the conditions and requirements for a Benefit. Proof of Claim must establish:

1. the nature and extent of the loss or condition;
2. Our obligation to pay the claim under the Policy; and
3. the Claimant's right to receive payment.

[Proof of Insurability: Evidence satisfactory to Us of a person's health and other information related to insurability which enables Us to determine whether the person can become insured, or is eligible for an increase in Coverage. This is also referred to as Evidence of Insurability.]

[Reservist: A member of a reserve component of the Armed Forces of the United States. "Reservist" also includes a member of the Army National Guard or the Air National Guard.]

Schedule of Benefits: Shows the amount of Benefits provided under this Policy.

[Severe Burn/Severely Burned: The Diagnosis, by a Doctor board-certified as a Plastic Surgeon, that a Covered Person has sustained third degree burns covering at least 20% of the surface area of his or her body.]

[Skilled Nursing Facility: An institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services. This definition **excludes** any home, facility or part thereof used primarily for rest; a home or facility primarily for the aged or for the care of drug addicts or alcoholics; a home or facility primarily used for the care and treatment of tuberculosis, mental diseases or disorders or custodial or education care.]

[Sign or Signed: The use by a person of a symbol or method with the present intention to authenticate a record. Such authentication may be executed and/or transmitted by paper or electronic media, provided it is acceptable to Us and consistent with the applicable law.]

[**Spouse**: Your lawful Spouse who is an Eligible Dependent.]

[Substantial Assistance: Hands-on assistance and stand-by assistance as described below. For the purposes of the Policy "stand-by assistance" will be used to determine that substantial assistance by another person is required by the Covered Person to perform Activity(ies) of Daily Living.

1. "Hands-on Assistance" means the physical assistance of another person without which a Covered Person would be unable to perform the ADL.
2. "Stand-by Assistance" means the presence of another person within a Covered Person's arm's reach, to prevent, by physical intervention, Injury to the Covered Person while he or she performs an Activity of Daily Living (such as being ready to catch him or her if he or she falls while getting into or out of the bathtub or shower as part of bathing, or being ready to remove food from the Covered Person's throat if he or she chokes while eating).]

[Stroke: Any acute cerebrovascular accident producing neurological impairment and resulting in paralysis or other measurable objective neurological deficit persisting for at least 96 hours and expected to be permanent. Transient ischemic attack (mini-stroke), head Injury, chronic cerebrovascular insufficiency and reversible ischemic neurological deficits are excluded. The Diagnosis must be made by a Doctor board-certified neurologist.]

[TNM Classification: The classification standards for Invasive Cancer and In Situ Cancer as developed by the American Joint Committee on Cancer.]

[Voluntary: An optional insurance program offered to You through the Policyholder where You pay all of the Premium for Coverage.]

We, Us, and Our: The insurer, Nationwide Life Insurance Company.

You and Your, Yourself: The Insured Person.

COVERED PERSONS PREMIUMS

When are Your Premiums due?

The first Premium for each Covered Person is due on the date [he or she becomes covered under this Policy.][he or she enrolls for insurance under the Policy.] Each Premium after the initial Premium is due at the end of the period for which his or her preceding Premium was paid.

[Your portion of the Premium due is payroll deducted by the Policyholder. The Policyholder remits the Premium to us or Our agent on or before the Premium Due Date. The payment of each Premium as it becomes due will maintain the Policy and Your insurance in force through the date immediately preceding the next Premium Due Date.]

[What happens if You are late with a Premium payment?

A Grace Period of [31-90] days from Your Premium due date is allowed for each Covered Person for payment of each Premium due after the initial Premium. The Covered Person's insurance will be continued during the Grace Period. If the Covered Person incurs a covered loss during the Grace Period, You will be liable to Us for payment of any Premium accruing during the period We continued Coverage You and Your covered Dependents.

The Grace Period will not continue Coverage beyond a date as described in the "**When will Coverage end?"** provision.]

[If I am able to continue insurance for myself and my Covered Dependents once I am no longer employed, how are premiums remitted:

If You satisfy the criteria of the **Portability of Insurance** Section, Our agent or We will bill You directly for the Premium due for You and Your Covered Dependents at the last address shown on Our records for You.]

WHEN COVERAGE BEGINS AND ENDS

Who is eligible?

Eligible Person: An individual is eligible for Coverage if he or she is in an Eligible Class as described in the Schedule of Benefits.

[Eligible Dependent: Your Eligible Dependents are also eligible for Coverage, provided that You are insured under the Policy and that Dependent Coverage is provided under the Policy.]

[Dual Eligibility Status: If both an Eligible Person and his or her [Spouse] [or Domestic Partner] are in an Eligible Class of the Policyholder, each may enroll individually or as a Dependent of the other[, but not as both]. Any Eligible Dependent Child may [be enrolled by both parents/guardians][only be enrolled by one parent/guardian]. [If the [Spouse][or Domestic Partner] carrying Dependent Coverage ceases to be eligible, please notify Us immediately. Dependent Coverage then becomes effective under the other [Spouse's][or Domestic Partner's] Coverage.]]

[When do You become Eligible for Critical Illness/Specified Disease Insurance?

You become eligible on [the first day of the calendar month coinciding with or next following] the date You become an Eligible Person and complete any applicable Eligibility Waiting Period as shown in the Schedule of Benefits.]

When do You enroll?

Enrollment is when an Eligible Person completes an Enrollment Form giving the information We require. [As the Eligible Person, if You are required to pay all or part of the Premium for Coverage, You must acknowledge Your permission to the Policyholder to withhold such Premium from Your Pay.] The enrollment for Coverage may be written or electronic on an Enrollment Form furnished or approved by Us.

[An Eligible Person who has met all eligibility requirements of the Group prior to the Policy Effective Date may request enrollment during the Initial Enrollment Period that precedes the Policy Effective Date. After the Policy Effective Date, an Eligible Person must request enrollment [during the Eligibility Waiting Period][no later than [30-90 days]] after [the date of hire][the end of the Eligibility Waiting Period][the date he or she becomes eligible][, unless there is a Change in Family Status as described below]. [If You enroll for Coverage as a result of a Change in Family Status, You must request enrollment within the [30-90] day period following the date of the event.]

If the plan provides for a Guaranteed Issue Benefit, an Eligible Person who enrolls for Coverage as indicated above may enroll for amounts of Coverage up to the Guaranteed Issue Benefit Amount without providing Proof of Insurability. Proof of Insurability will be required for amounts of Coverage in excess of the Guaranteed Issue limit.

If You do not enroll for Coverage as indicated above You will be considered a late enrollee [and You may not enroll until the next Enrollment Period]. [If you enroll as a late enrollee, You must furnish to Us, at Your cost, adequate Proof of Insurability for [all amounts of coverage] [amounts of coverage in excess of the Guaranteed Issue limit] before you can become covered].]]

{or}

[An Eligible Person who has met all eligibility requirements of the Policyholder may enroll at any time throughout the Plan Year. The Enrollment Form must be completed and Signed on or before the desired Effective Date of Coverage.] [Proof of Insurability will be required for [all amounts of Coverage][amounts of Coverage in excess of the Guaranteed Issue limit.] You will be responsible for the cost of providing Proof of Insurability.]

[Eligible Dependent*:* If the Policy provides for Dependent Coverage, an Eligible Person who has met all eligibility requirements of the Group prior to the Policy Effective Date may also request enrollment of his or her Eligible Dependents [at any time throughout the Policy Year.] [during the Initial Enrollment Period that precedes the Policy Effective Date. After the Policy Effective Date, if You acquire a new Dependent per the "Change in Family Status" provision below, as an Insured Person, You may request enrollment for Your Dependent within the [30-90] day period following the date of the event.]

[If the plan provides for a Guaranteed Issue Benefit, an Eligible Dependent who enrolls for Coverage as indicated above may enroll for up to the Guaranteed Issue Benefit Amount without providing Proof of Insurability. Proof of Insurability will be required for amounts of Coverage in excess of the Guaranteed Issue limit.]

[If You do not enroll for Dependent Coverage as indicated above, Your Dependent will be considered a late enrollee [and You must furnish to Us, at Your cost, adequate Proof of Insurability for [all amounts of coverage for] [amounts of coverage in excess of the Guaranteed Issue limit for] each Dependent before the Dependent can become covered]. [The Dependent may not enroll [until the next Enrollment Period] unless there is another *Change in Family Status*, as described below]. [Proof of the Dependent relationship may be required by Us.]

[This requirement will continue even if Your job with the Policyholder ends and You are later rehired.]]

[If an Eligible Person is required to give Proof of Insurability for all or a portion of his or her insurance, We will provide forms for providing such Proof and instructions for their completion.]

[Change in Family Status: Eligible Persons may enroll or change their Coverage outside of an Enrollment Period if a change in family status occurs. A change in family status means any of the following:

1. Marriage [or lawful domestic partnership][civil union];
2. Divorce or legal separation;
3. Birth, adoption, or Placement for Adoption of a Child;
4. Death of a [Spouse] [or Domestic Partner] or Child;
5. A court or administrative order requiring the Eligible Person to provide Coverage for his or her Child;
6. Other changes as permitted by the Policyholder and Us.]]

[Enrollment Period: The Policyholder may provide for an Enrollment Period during the Policy Year. Eligible Persons may enroll themselves [and their Eligible Dependents] during an Enrollment Period as if they were a newly Eligible Person [subject to providing Proof of Insurability [for all amounts of coverage] [for amounts of coverage in excess of the Guaranteed Issue limit]]. They may also [increase,] [decrease,] [or] [terminate] coverage during such Enrollment Period. [If the Covered Person has coverage in force and is requesting an increase in the Benefit Amount, [but the Benefit Amount has not reached the Guaranteed Issue Amount, such person may enroll for additional insurance up to the Guaranteed Issue amount without providing satisfactory Proof of Insurability. Any amounts in excess of the Guaranteed Issue amount are subject to satisfactory Proof of Insurability.] [all increases in Benefit Amount are subject to Proof of Insurability.] If Proof of Insurability is required, Coverage is effective on [the next Policy Anniversary date following] [the first of the month following] the date we approve Proof of Insurability[, provided You are Actively at Work [or] [Your Dependent is not confined in a Hospital or other medical facility] on the date the increased benefit would become effective]. The effective date of coverage will be deferred as described above. Decreases in coverage will

become effective on [the Policy Anniversary date that follows the Enrollment Period] [the first day of the month following] [the date of Your request].]

[When will Your Coverage begin?

[If the Policyholder requires You to contribute toward the cost of all or part of the insurance, no such Contributory insurance will become effective for You before You agree to make the required contributions and the first Premium is paid. The form may be obtained from the Policyholder.]

[For Guaranteed Issue Benefit Amounts:]
Subject to [the Eligibility Waiting Period] [and] Your enrollment [and payment of any Contributory portion of the Premium due], insurance is effective on the later of 12:01 AM at the main office of the Policyholder on [Your first day of Coverage]:

1. [the Policy Effective Date, if You are eligible prior to the Policy Effective Date, You enroll and You pay the Contributory portion for the entire amount requested; or
2. the [first of the month following] date an Eligible Person enrolls [and pays the Premium due for the entire amount requested], if an Eligible Person enrolls for Coverage after the Policy Effective Date.]

[Notwithstanding the above, if You are not Actively at Work on the date Your insurance Coverage would begin, Your insurance will begin on the date You come back to Active Work.]

[For Benefit Amounts in excess of the Guaranteed Issue Benefit Amount, the additional coverage will be effective on [the first of the month following] the date that We approve the Proof of Insurability.]

[In any event, if You enroll for insurance more than [30-90] days after You became eligible, Your insurance will be deferred until the date We approve Your written Proof of Insurability.]

[When will Coverage begin for Your Dependents?

[For Guaranteed Issue Benefit Amounts:]
Subject to the enrollment procedures described in **When do You enroll** above [and payment of any Contributory portion of the Premium due], insurance is effective on the later of 12:01 AM at the main office of the Policyholder on:

1. The date Your insurance becomes effective if you elected Dependent Coverage when You initially enrolled; or
2. If You acquire additional Dependents after Your Effective Date of Coverage, and provided You enroll Your newly Eligible Dependents as indicated above and pay any required Premium due, the Effective Date will be the [first of the month following] date You enroll such Dependent;

For Benefit Amounts in excess of the Guaranteed Issue Benefit Amount, the additional coverage will be effective on the [first of the month following] date that We approved that person's Proof of Insurability.

With regard to newborns or a child Placed for Adoption, the Enrollment Form must be completed prior to the expected birth of a child or Placement. If You did not elect Dependent Coverage before the birth or Placement of a child, Coverage on that child will not be denied, with respect to Critical Illness Insurance if You notify Us in writing of the birth or Placement of such child and [authorize the Policyholder to make the required payroll deductions][make any Premium payment due] toward the cost of Dependents Coverage, within [30-90] days of the date of birth or Placement. If You already have Dependent Coverage for one Dependent, Dependent Coverage for a newborn or child Placed for Adoption will be added without Proof of Insurability. However, We require You to notify Us of additional Dependents [within [30-90] days of the date of birth or Placement for Adoption] to assure accurate claims handling.

[The Policyholder may require employees to contribute toward the cost of all or part of their Dependent insurance. If so, the only Eligible Dependent who may become insured before You agree to those contributions is Your newborn Child. The form for this agreement may be obtained from the Policyholder. [If You Sign the form more than [31-90] days after You became eligible for Dependent insurance, the insurance for each Eligible Dependent will be deferred until the date We approve Proof of Insurability for each Eligible Dependent as described above.]]

[Are there situations when Your Dependents' Effective Date may be deferred?

If any Eligible Dependent, other than a newborn child, is confined due to Injury or Illness in a Hospital or other medical facility on the date insurance would otherwise begin, Coverage will become effective on the first day following the date the Dependent is no longer confined as long as Your Coverage is in effect.]]

[When will Benefits [and/or rates] change?

Change in Eligible Class: Your [and Your Eligible Dependents] [rates and/or] Benefit Amount may change if You become insured under a different Eligible Class.

[The change][If the change would increase the amount of insurance [and/or rates], the increase] takes effect on the [next Policy Anniversary] [first day of the Policy month [You are Actively at Work]] [following] the latest of the date:

1. the change occurred;
2. the Policyholder tells Us [in Writing] about a change in Class;
3. we approve any Proof of Insurability required for a benefit increase; or
4. the Premium is paid based on the change.

[If You are not Actively at Work, such change will be effective on the first day on which You return to work. If You or Your Policyholder do not make the required payment within [30-90] days of the change, any increased Benefits will not be effective until You give Proof of Insurability satisfactory to Us. Such increased Benefits will be effective on a date set by Us.]

[If the change would *decrease* Your amount of insurance [and/or rates], the decrease takes effect [on the next Policy Anniversary] [the first of the month following the date of the change][on the date of the change].]

[Changes in Benefits due to an Amendment to the Policy: Once Your coverage begins, the amount of Your Benefit [and/or Benefits for Your Covered Dependents] may change due to an Amendment to the Policy as follows:

For You:

If You are Actively at Work performing all the normal duties of Your job for a full work day, Benefit changes will take effect:

1. on the Amendment effective date, if Proof of Insurability is not required ; or
2. on the [first of the month following the] date We approve Your Proof of Insurability.

If You are not actively at work on the Amendment effective date, Benefit changes will be effective on the date You return to Actively at Work status.

[For Your Dependent (if applicable):

If the Dependent is not confined to a Hospital, Benefit changes will take effect:

1. on the Amendment effective date, if Proof of Insurability is not required; or
2. on the [first of the month following the] date We approve the Dependent's Proof of Insurability.

If the Dependent is Hospital Confined on the Amendment effective date, Benefit changes will be effective on the day after the Dependent is released from a Hospital.]

[Changes requested by You:

Once You have made Your Benefit elections for a given year, You may not change the Benefit Amount until the Policyholder's Enrollment Period or due to a Change in Family Status in accordance with the "When Do You Enroll" section of the Policy. This right includes increases, decreases, and terminations.]]

When will Coverage end?

[Subject to the Portability of Insurance Section,] all of Your insurance under the Policy will terminate at 12:01 AM. at the main office of the Policyholder on the earliest of the following dates:

1. [The [date] [last day of the month in] which Your employment terminates. For the purposes of insurance coverage Your employment will terminate when You are no longer Actively at Work.]
2. The date the Policy terminates;
3. [The [date][last day of the month] Your [employer, company] ceases to be an Affiliated [employer, company] with the Policyholder;]
4. [The [date][last day of the month in which] You cease to be an Eligible Person[,unless Benefits are extended under the **May coverage continue during a temporary absence from employment?** provision noted below];]
5. The date specified by Us in written notice to You that Your Coverage ends due to fraud or misrepresentation;
6. The [date][last day of the month in which] We receive written notice from You [or the Policyholder] telling Us to terminate Coverage of a Covered Person or the date requested in that notice, whichever is later;
7. The last day of the period for which Premium was paid, if a Premium is not paid when due;

8. The [date] [last day of the month] in which] the Policy is changed to end the insurance for Your Eligible Class;
9. [The [date][last day of the month in which] You retire unless Your insurance is continued in a retired Eligible Class [as defined by the Policyholder][as shown in the Schedule of Benefits];]
10. [The [date][last day of the month in which] You enter full-time active duty in the armed forces of any country or international authority;]
11. [The [last day of the month following][date of] Your [50th – 99th] birthday;]
12. [The date You reach the Per Person Lifetime Benefit Maximum Payout;] or
13. The date of Your death.

[In addition, Coverage will be terminated on the first day of the calendar month following any month in which the number of hours worked falls below the minimum required hours as elected by the Policyholder.]

[[Subject to the Portability of Insurance Section,] your Dependent's insurance under the Policy will terminate at 12:01 AM at the main office of the Policyholder on the earliest of the following dates:

1. The date the Policy terminates;
2. [The [date][last day of the month] the Dependent ceases to be an Eligible Dependent] *or* [if the Dependent ceases to be an Eligible Dependent, the earliest of:
   a. the [date][last day of the month] the Dependent reaches his or her maximum age under the Policy; or
   b. the [last day of the month] following a [1,2,3] year period of time from the date the Dependent lost eligibility;]
3. The [date][last day of the month in which] You cease to be insured under the Policy[, unless Benefits are extended under the **May coverage continue during a temporary absence from employment?** provision noted below];]
4. The [date][last day of the month in which] You cease to be in an Eligible Class for Dependent Coverage;
5. The last day of the period for which Premium was paid, if a Premium is not paid when due;
6. The [date][last day of the month] We receive written notice from You or the Policyholder telling Us to terminate Coverage on any Dependent or the date requested in that notice, whichever is later;
7. The [date] the Policy is changed to end the insurance for Your Eligible Class;
8. [The [date] that the Dependent enters full-time active duty in the armed forces of any country or international authority;]
9. [For Your Dependent [Spouse][or Domestic Partner] [the [last day of the month following][date of][Your][his or her] [50th – 99th] birthday;]
10. [The [date][last day of the month in which] You retire;]
11. [The date the Covered Dependent reaches the Per Person Lifetime Benefit Maximum Payout;] or
12. The date of Your death [or retirement].

[Handicapped Dependent Children: Insurance will continue for a handicapped child who has attained the limiting age for Eligible Dependents, if such child is unwed and mentally or physically incapable of earning their own living; and dependent on You for support and maintenance and was covered on the day immediately prior to attaining the limiting age. Proof of incapacity must be furnished to Us within [30,31,60,90] days of attainment of the limiting age.]]

[Notice Required When Your Coverage Terminates: [The Policyholder] [You] must inform our agent or Us within the [30-90] days of the date Your Coverage terminates for any reason. Failure to provide timely notice will not continue Your insurance past the time it would have otherwise ended as provided above. In the event Premiums have been paid to Us on Your behalf after Your Coverage should have terminated, We will refund the Premium for the period for which Premiums were paid in error up [1-12] Policy month(s) [or to the last Policy Anniversary, whichever is less]. If We are not notified that Your Coverage is terminated and We pay any Benefits after the date Your Coverage terminated, You will be responsible for payment of all Premiums due through the Policy month in which Benefits were paid.]

[May Coverage be reinstated if I return to [Active Work][eligible status]?

[After release from active duty: If Your insurance or Your Eligible Dependent's insurance ends due to Your being called or ordered to full-time active duty in the armed forces of any country or international authority, such insurance will be reinstated without any Eligibility Waiting Period when You return to Active Work.]

[After loss of eligibility: If You meet the definition of Eligible Person [within the same Plan Year][but no more than][[within][30 days – 1 year][of the date Your Coverage terminated], You may re-enroll for insurance under this Policy. We will give You [and Your Covered Dependents] credit for any portion of the [Eligibility Waiting Period] [and] [Benefit Waiting Period] satisfied prior to termination.]

[After termination of employment; If Your employment with the Policyholder ends and You are rehired by the same employer and return to Active Work within [30-180 Days][1-3 Year(s)] of the date your employment terminated, Your previous period of Coverage in an Eligible Class will be applied toward completing the [Eligibility Waiting Period] [and] [Benefit Waiting Period].]

[If You do not qualify for reinstatement within [30 days-1 year] from the date You were last eligible or do not satisfy the conditions indicated above, You shall be treated as a new Eligible Person].]

[May Coverage continue during a temporary absence from employment?

Yes, if Premium is paid, coverage may be continued on Active Insured Persons absent from work subject to the following provisions. If an Active Insured Person is absent from work because of [Injury or Illness,][Family Medical Leave,][approved Leave of Absence,][or temporary lay-off][, or is placed on Part-time employment,] the Policyholder, acting on a basis which does not discriminate for or against any person, may consider the Active Insured Person as still employed until the Policyholder notifies Us differently or stops paying Premiums for the Active Insured Person. However, in any event, insurance cannot be continued in this way for longer than the Maximum Continuation Period stated below:

FOR ABSENCE DUE TO:	**MAXIMUM CONTINUATION PERIOD:**
[Temporary Lay-Off	[30 days – 2 years] [through the end of the month][following the [date][month] in which Your Lay-Off began]]
[Approved Leave of Absence	[30 days – 2 years] [through the end of the month][following the [date][month] in which Your Leave of Absence began]]
[Part-Time Employment	[30 days – 2 years] [through the end of the month][following the [date][month] in which Your Part-Time Employment began]]
[Injury or Illness	[30 days – 2 years] [through the end of the month][following the [date][month] in which Your Injury or Illness began]

~or~

[One-year periods, each of which begins on the Anniversary Date of this Policy, subject to the following conditions:

1. The first period begins on the date the Active Insured Person stops Active Work due to Injury or Illness and ends on the next following Anniversary Date of this Policy;
2. Request to continue insurance must be made by the Policyholder to Us within 31 days before each Anniversary Date.]]

[Family or Medical Leave (FMLA): Coverage will be continued in accordance with Your employer's Human Resource policy on family and medical leaves of absence if Your employer approved Your leave in writing and Premiums continue to be paid.

Coverage will be continued for up to the greater of:

1. the leave period required by the Federal Family and Medical Leave Act of 1993, and any amendments;
2. the leave period required by applicable state law[;or]
3. [the Maximum Continuation Period for Injury or Illness].]

[What happens to my Dependents' Coverage if I die, [or] retire, [or reach the Per Person Lifetime Benefit Maximum Payout]?

If You die or retire while insured for Dependent Group Critical Illness Insurance coverage [or Your coverage terminates because You have reached the Per Person Lifetime Benefit Maximum Payout shown in the Schedule of Benefits,] Your Dependents Coverage will also terminate.]

[PORTABILITY OF INSURANCE

[Insurance provided under this Benefit does not continue coverage for the following Additional Benefits: [At Home Recovery Benefit;] [Child Care Benefit;] [Loss of Independent Living Benefit;] [Skilled Nursing Confinement Benefit;] [Wellness Benefit].]

May You continue insurance after termination of eligibility?

Portability of insurance is the continuation of [some or all of] [the Policy's] Coverage after termination of Your employment or eligibility under Your Eligible Class while the Policy is in force. The Premium for the Portable Coverage will be determined by the Policy type, Your risk classification, Our published rates in effect and Your Policy age at the time of application. [Premium rates will increase annually on [Your date of birth] [the first of the month following your date of birth].] You must pay the Premium for the Portable Coverage directly to Us. You must apply for, and be eligible for, this Coverage pursuant to the following terms of this provision.

[Portable Coverage is not available for Covered Dependent's Coverage.][Portable Coverage is not available for Covered Dependent child(ren).]

Who may become Insured?

The Eligible Class or Eligible Classes of persons who may be insured under this provision are all of those who satisfy all of the following conditions.

1. [You were insured by Us [for at least [1-36] [month, months]].]
2. [Your] Critical Illness insurance provided by the other terms of the Policy has terminated due to [termination of Your employment] [or] termination of Your Eligible Class of Coverage prior to termination of the Policy.]
3. [You are under [50-99] years of age.]
4. [You did not terminate employment [due to a Disability or covered Critical Illness] [and] [You have not attained Your Retirement Date].]
5. [Your [Covered Spouse][Covered Dependents] will also be allowed to apply for Portable Coverage so long as You elect Portable Coverage [and the Covered Dependent(s) are under [50-99] years of age], and are otherwise eligible under the Eligible Dependent Definition.]

How and when will insurance continue?

You must elect by written application to continue Coverage under this provision within the [1-365] day period immediately following the date on which Your insurance terminated.

If Your Premium and application are received by Us within this period, Portable Coverage will take effect on the [1st-30th] day immediately following the date of termination.

An application to become insured must be completed on a form approved for that purpose by Us. It must be received by Us at Our [Home Office][Administrative Office] within the [1-365] day time period.

No amount or type of Coverage will be eligible to be continued under this Portability option unless such amount and type of Coverage is elected on the initial written application for Portable Coverage. No amount or type of Coverage may be included in the Portable Coverage if You [or Your Dependent] were not insured for the same amount and type of Coverage at the time Your employment or eligibility under the Policy would otherwise have terminated and You became eligible for Portable Coverage.

Will there be Premium rate changes for Portable Coverage?

We may change Premium rates for Portable Coverage at any time for reasons which affect Our risk assumed, including but not limited to the following:

1. Changes occur in the Coverage levels.
2. Changes occur in the overall use of Benefits by all Covered Persons.
3. Changes occur in other risk factors.
4. A new law or change in existing law that is enacted which affects the risk assumed.

The change in Premium rates will be made on a class basis according to Our underwriting risk assessments. We will notify You in writing at least [30-365] days before a Premium rate is changed.]

Do Benefits reduce for Portable Coverage?

Reductions in the amount of Portable Coverage will occur in accordance with the Age Reductions shown in the Schedule of Benefits.

When do Portable Coverage and Portable Coverage Eligibility end?

Any Portable coverage in effect, and all eligibility for new Portable coverage ends at 12:01 AM on the earliest date shown below:

1. On the last day of the period for which Premiums have been paid in accordance with the Grace Period;
2. [On the day before You enter full-time active duty in the armed forces of any country or international authority;]
3. On the date on which You request, in writing, to have the insurance terminated;
4. [On the date You attain Your Retirement Date;]
5. [[12-60] months from the effective date of the Portable coverage**;**]
6. [On Your [65-75th] birthday;]
7. [On the date of the termination of the Policy];
8. [The date You reach the Per Person Lifetime Benefit Maximum Payout;] or
9. On the date of Your death.

[Any Dependent's Portable coverage in effect, and all eligibility for new Dependent Portable coverage ends at 12:01 AM on the earliest date shown below:

1. On the last day of the period for which Premiums have been paid in accordance with the grace period;
2. [On the day before the Dependent enters full-time active duty in the armed forces of any country or international authority;]
3. On the date on which You request in writing to have the insurance on Your Dependents terminated;
4. On the date on which the Dependents insurance under the Policy is no longer in force;
5. When the Dependent ceases to be an Eligible Dependent as defined under the Policy;
6. On termination of Your insurance under the Policy;
7. [The date Covered Dependent reaches the Per Person Lifetime Benefit Maximum Payout;] or
8. The date of Your death.]

You or Your legal representative must notify Us in writing within [30-365] days after the date on which an event described above occurs.

Portable Coverage that has been terminated cannot be reinstated. If You elect Portable Coverage and You again become an Eligible Person of the Policyholder, Your Portable Coverage will end when You become eligible under the Policyholder's Policy.

Definitions for Portability provision:

Disability: You are unable to work and are unable to perform the substantial and material duties of Your own occupation for which You are qualified in view of age, education, experience and physical and mental capacity.

Grace Period: With respect to payment of each Premium, the [1-365] [day,days] after the date on which it is due. The Portable coverage will remain in force during the Period of grace unless terminated in accordance with the Termination of Policy provision. In any event, Premiums are payable for any period of grace during which the Portable coverage continues in force.

Own Occupation: The duties You regularly performed for which You were covered under the Policy immediately prior to the date Your Disability began.

Retirement Date: The date You [[begin receiving retirement Benefits which You are eligible to receive as a result of past employment, whether or not the retirement Benefits were funded in whole or in part by a previous employer. This also includes retirement income from any federal, state, municipal or association plan] [or] [attain normal retirement age under the 1983 United States Social Security Act, and any amendments thereto].

Policy Age: Your age calculated by subtracting the year of Your birth from the current year as of the date of Your election.

Portable Coverage: The insurance Coverage provided, if applicable, by the Portability of Insurance provision.]

BENEFITS

What benefits are payable for a Critical Illness?
We will pay the Percent of the Benefit Amount shown in the Schedule of Benefits for:

1. A Critical Illness Diagnosis that is made after the Benefit Waiting Period; or
2. A Critical Illness Procedure that is performed after the Benefit Waiting Period,

while a Covered Person is insured under this Certificate.

[[Benefit Waiting Period: Benefits will not be paid for a Critical Illness:

1. if the First Occurrence is during the Benefit Waiting Period; or
2. for which a Covered Person exhibits symptoms of a covered Critical Illness that would cause an ordinarily prudent person to obtain medical treatment from a Doctor during the Benefit Waiting Period.]

~or~

[Benefit Waiting Period: Benefits otherwise payable under the Policy will be reduced to the percentage amount indicated in the "Benefit Waiting Period Reduction" shown in the Schedule of Benefits for a Critical Illness:

1. if the First Occurrence occurs after Your Effective Date and during the Benefit Waiting Period; or
2. for which an Insured exhibits symptoms of a covered Critical Illness that would cause an ordinarily prudent person to obtain medical treatment from a Doctor during the Benefit Waiting Period.]

[If :

1. the date of Your First Occurrence of a covered Critical Illness occurs after Your Effective Date and during the Benefit Waiting Period; and
2. the Policy is a new program for the Policyholder [or You were not covered under the Prior Plan].

You may return the Certificate for a full premium refund and the coverage will be terminated. [You must notify Us in writing.]]

[If :

1. the date of a Covered Person's (other than Yourself) First Occurrence of a covered Critical Illness occurs after his or her Effective Date and during the Benefit Waiting Period; and
2. the Policy is a new program for the Policyholder and there is no Prior Plan,

You may terminate the person's coverage under the certificate for a premium refund of that person's cost and his or her coverage will be terminated. [You must notify Us in writing.]]]

[Survival Period: No benefit will be paid if a Covered Person dies within the [30, 60, 90] day period immediately following the First Occurrence. The Covered Person must remain alive and exhibit symptoms of the Critical Illness throughout the [30, 60, 90] day survival period.]
~or~
[Survival Period: If the Covered Person dies within the [30, 60, 90] day period immediately following the First Occurrence, the benefit otherwise payable under the Policy will be reduced to the percentage amount indicated in the "Survival Period Reduction" shown in the Schedule of Benefits.]

[First Occurrence[*]: We will pay the Percent of the Benefit Amount shown in the Schedule of Benefits for each and every covered Critical Illness up to the [Per Category Maximum Total Percent of Benefit][, or the][Per Person Lifetime Benefit Maximum Payout] if the following conditions are met:

1. With respect to [Invasive Cancer,] [In Situ Cancer,] [Advanced Alzheimer's Disease,] [Heart Attack,] [End Stage Renal Failure,] [Motor Neuron Disease,] [Stroke,] [Paralysis,] [Advanced Parkinson's Disease,] [Loss of Independent Living,] [Occupational HIV,] [Blindness,] [Coma,] [Severe Burn,] [Loss of Limb], the first time after a Covered Person's Effective Date that he or she is Diagnosed with or experiences such Critical Illness..
2. [With respect to [Coronary Artery Bypass Graft,] [Heart Valve Replacement/Repair,] [Angioplasty,] [Aortic Surgery], the first time after a Covered Person's Effective Date that he or she undergoes such Procedure.]
3. [With respect to [Major Organ Transplant,] [Heart Transplant], the first time after a Covered Person's Effective Date that he or she is registered by the United Network of Organ Sharing (UNOS) or the National Marrow Donor Program (NMDP) for [Major Organ Transplant] [or] [Heart Transplant]].

If the date of Diagnosis for two or more specified Critical Illnesses is the same day, We will pay for only one specified Critical Illness Benefits. We will pay the larger Benefit.

[* The reference to First Occurrence is subject to the Pre-existing Conditions provision. [Once a Pre-existing Condition period is satisfied, a Diagnosis or Procedure recommended is considered a First Occurrence for the Covered Person.]]]

[Additional Critical Illness Benefit: If a Covered Person received benefits under the First Occurrence for a Critical Illness, he or she will receive benefits for a First Occurrence of a different Critical Illness as long as the date of Diagnosis or Procedure for each Critical Illness is separated by at least [6,12,18,24] consecutive months. We will pay the Percent of the Benefit Amount shown in the Schedule of Benefits, up to the [Per Category Maximum Total Percent of Benefit][, or the] [Per Person Lifetime Benefit Maximum Payout] shown in the Schedule of Benefits.**]**

[Recurrence Benefit
If a Benefit is paid for a First Occurrence of a Critical Illness, the Insured has not exhibited symptoms that would cause an ordinarily prudent person to seek medical treatment from a Doctor or received care and treatment for that same Critical Illness from a Doctor for at least [6, 12, 18, 24] consecutive months since the First Occurrence and the Insured is re-diagnosed for the same Critical Illness, We will pay a Recurrence Benefit as follows:

1. With respect to [Heart Attack] [End Stage Renal Failure] [Stroke], the second time after a Covered Person's Effective Date that: (a) he or she experiences such Critical Illness; and (b) he or she is diagnosed with such Critical Illness.
2. With respect to [Major Organ Transplant] [Heart Transplant], the second time after a Covered Person's Effective Date that he or she or she undergoes a [Major Organ Transplant] [Heart Transplant].

Care and treatment does not include preventive medications in the absence of an Illness or disease or routine scheduled follow up visits to a Doctor.

[Per Category Maximum Total Percent of Benefit: Within each Category, the most We will pay for the First Occurrence Benefit, [and] [all Additional Critical Illness Benefits], [and all Recurrence Benefits] [combined] is the Per Category Maximum Total Percent of Benefit shown in the Schedule of Benefits. [The Recurrence Benefit is not applied to the Maximum Total Percent of Benefit.]

[Per Person Lifetime Benefit Maximum Payout: The Per Person Lifetime Benefit Maximum Payout is shown in the Schedule of Benefits. Once the [Per Category Maximum Total Percent of Benefit has been met for each Category of Critical Illness][, or the] Per Person Lifetime Benefit Maximum Payout is met for a Covered Person[, if earlier,] no additional benefits are payable for that Covered Person. If the Covered Person is You, the coverage will terminate for You [and Your covered Dependents][, subject to the provision entitled **What happens to my Dependents' coverage if I die, retire, or reach the Per Person Lifetime Benefit Maximum Payout?]**

.

ADDITIONAL BENEFITS

[At Home Recovery Benefit: If a Covered Person is Hospital confined due to treatment of Invasive Cancer, upon discharge from a Hospital confinement, We will pay an at Home Recovery Benefit for home recovery services provided the Covered Person:

1. had completed the Benefit Waiting Period (shown in the Schedule of Benefits) prior to confinement in a Hospital; and
2. had been confined in a Hospital after a positive Diagnosis of the Covered Person's First Occurrence of Invasive Cancer.

The At Home Recovery Benefit Amount is shown in the Schedule and is a daily benefit amount for each day that the Covered Person was Hospital confined as an Inpatient for the Invasive Cancer.

We will increase our payment to two times the Daily Benefit Amount for each day [or portion of a day for confinement of at least 8 hours] that a Covered Person is required to be in an Intensive Care Unit during such Inpatient confinement for Invasive Cancer.

We do not pay benefits for the Hospital confinement under this Benefit.]

[Child Care Benefit:
We will pay You the benefit stated in the Schedule of Benefits for each of Your Dependent Children who are covered under the Policy if You are Diagnosed with [Paralysis][Coma][Loss of Independent Living] and a benefit is payable under the Policy for such Critical Illness. [If You do not have any Dependent children who qualify for this Benefit, We will pay You the benefit stated in the Schedule of Benefits.]

You must be covered under the Policy on the date of such Diagnosis is made or Procedure is recommended.

The benefit shall be paid for each Dependent child who, on the date of such Diagnosis is made or Procedure is recommended, was:

1. less than [13] years of age;
2. attending a licensed child care center on a full-time basis; or
3. enrolled within [30-365] days after the date of such Diagnosis or Procedure, in a licensed child care center on a full-time basis.

The Dependent child must continue to enroll and attend a licensed child care center on a full-time basis for the benefits to be paid.

The first benefit will be paid on the later of:

1. the date the Critical Illness Benefit is paid; or
2. the date the Company receives proof that the Dependent child is attending a licensed child care center on a full-time basis after such Diagnosis is made or Procedure is recommended.

Additional [annual] payments will be paid on the date the Company receives proof that the Dependent child is attending a licensed child care center on a continuous full-time basis.]

[Loss of Independent Living Benefit: If a Covered Person attains age [60,65,70,75] while covered under the Policy and suffers a Loss of Independent Living due to an Illness or Accidental Injury, We will pay the lump sum benefit shown in the Schedule of Benefits. This benefit is paid in addition to any other benefits payable under the Policy.]

[Skilled Nursing Facility Confinement Benefit: If a Covered Person is confined to a Skilled Nursing Facility as an Inpatient due to a Critical Illness We will pay a benefit amount shown in the Schedule of Benefits as the Daily Skilled Nursing Facility Confinement Benefit.

This benefit will be paid from the first day of confinement and for each day of confinement, up to the Maximum Payment Period shown in the Schedule of Benefits.

]

[Wellness Benefit
In addition to other benefits payable under the Policy, We will pay this benefit if a Covered Person has one of the following screening tests performed [after the Benefit Waiting Period and] while coverage under this Certificate is in force. We will pay the amount shown in the Schedule of Benefits for one of the following screening tests. Payment of this benefit will not reduce the Benefit Amount Payable for a Critical Illness. This benefit is payable only once and for only one test per Plan Year for a Covered Person.

Screening test is defined as:

- Stress test on a bicycle or treadmill
- Fasting blood glucose test
- Blood test for triglycerides
- Serum cholesterol test to determine level of HDL and LDL
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (cancer antigen 15-3 - blood test for breast cancer)
- CA125 (cancer antigen 125 - blood test for ovarian cancer)
- CEA (carcinoembryonic antigen - blood test for colon cancer)

- Chest X-ray
- Colonoscopy
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum Protein Electrophoresis (blood test for myeloma)
- Thermography
- ThinPrep Pap Test
- Virtual Colonoscopy
- Screening for Abdominal Aortic Aneurysm
- [H1N1] vaccination *{carrier may add other vaccines as deemed appropriate }*]

EXCLUSIONS AND LIMITATIONS

Benefits are not provided for a Critical Illness due to or resulting from:

1. Committing or attempting to commit a felony or engaging in any illegal occupation, riot or insurrection;
2. An act or accident of war, declared or undeclared, whether civil or international, or any substantial armed conflict between organized forces of a military nature;
3. Suicide or any attempt at suicide while sane [or insane]
4. Serving in the armed forces or any auxiliary union of the armed forces of any country.
5. Voluntarily taking or using any drug, medication or sedative unless it is:
    a. Taken or used as prescribed by a Doctor; or
    b. An 'over the counter' drug, medicine or sedative taken according to the package directions; or
6. A Covered Person's involvement in an incident where he or she is legally intoxicated at the time of the incident. This includes, but is not limited to, his or her or her operation of a motor vehicle. "Legally intoxicated" means that the Insured's alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred.

We will not pay benefits for a Critical Illness for which a Diagnosis is made or a Procedure recommended outside the United States, unless the Diagnosis or Procedure is confirmed in the United States by a Doctor qualified to make the Diagnosis or Procedure based on the conditions of the Critical Illness, as defined herein. In this situation, the Diagnosis will be deemed to have been made or the Procedure will be deemed to have been recommended on the date it is made outside the United States.

[PRE-EXISTING CONDITIONS LIMITATION

Are there limitations on conditions for which a Covered Person was treated prior to the Effective Date of his or her Coverage?

Yes. There may be limits on Pre-existing Conditions.

What is a Pre-existing Condition and how does it affect the Benefits?

A Pre-existing Condition is any condition [(a) that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the [3,6,12,24] months immediately prior to a Covered Person's Effective Date;] or [[(b)] for which medical advice, diagnosis, care or treatment was recommended or received within [3,6,12] months immediately prior to a Covered Person's Effective Date;]] The [3,6,12,24] month period is called a look back period.

Benefits are not provided for a Diagnosis made or Procedure recommended for a Pre-existing Condition under the Policy.

A condition will no longer be considered a Pre-existing Condition for any Covered Person [who is not a late enrollee per the "When do You enroll" provision] after such person has been covered for [6, 12, 24] consecutive months from his or her Effective Date. [If a Covered Person is a late enrollee, a condition will no longer be considered a Pre-existing Condition after a Covered Person has been covered for [12, 18, 24] consecutive months from his or her Effective Date.]

[With respect to a benefit increase, We will not pay benefits for such benefit increase for a Critical Illness that is caused by or results from a Pre-existing Condition if the Critical Illness occurs during the first [6, 12, 24] months after such increase in the Benefit Amount.]]

CLAIMS PROVISIONS

Submitting Claims and Receiving Reimbursement

*How to submit a Claim:[*Written notice of Claim and request for Claim forms must be given to Us within [20,30,60,90] days after the loss or as soon after as is reasonably possible. Upon receipt by Us of such request, We will send Claim forms for providing Proof of Loss within [10-90 days] to the Claimant, You or Your representative and instructions as to how they should be completed and where they should be sent. Claimants should be sure to fully complete the forms. Incomplete forms may delay the processing of the Claim.] For a Claim for loss of life, a certified copy of the death certificate must be provided to Us.

When to submit Proof of Loss: Written Proof of Loss must be provided within [30-180] days from the date of loss. We will not deny or reduce any Claim filed after [30-180] days from the date of loss if:

1. it was not reasonably possible to file the Claim within that [30-180]-day period.
2. the Claim is filed as soon as it is reasonably possible.

In any event, Proof of Loss must be given to Us [in a reasonable time.] [within [1-3] year(s) after it is due, unless You are legally incapable of doing so.]

What If additional information is required? When We receive Notice of Claim that does not contain all necessary information or is not on an appropriate Claim Form, forms for filing Proof of Loss will be sent to the Claimant along with a request for the missing information.

When and to whom will the Claim be paid? After receiving written Proof of Loss and Premium payment, We will pay all Benefits then due for Claims directly to You. We will pay all Claims or any portion of any Claims within [30-180] days, or as required by Your state, after receipt of the Claim. If a Claim or a portion of a Claim is contested by Us, You shall be notified in writing, that the Claim is contested or denied, within [30-180] days after receipt of the Claim by us. The notice that a Claim is contested shall identify the contested portion of the Claim and the reasons for contesting the Claim. Upon receipt of the additional information requested from You, We shall pay or deny the contested Claim or portion of the contested Claim, within [30-180] days. We shall not pay or deny any Claim later than [30-180] days after receiving the Claim.

All payments made to or by Us will be made in United States dollars.

May We conduct physical examinations and autopsy? We shall have the right and opportunity to have any Covered Person whose Critical Illness is the basis of a Claim undergo an independent medical exam. This may be done when and as often as We may reasonably require. If the person has died, We may require an autopsy, unless it is prohibited by law. Such examination or autopsy will be at Our expense.

GENERAL PROVISIONS

Assignment

We will recognize any assignment made by You under the Policy provided it is duly executed and a copy is on file with Us. We and the Policyholder assume no responsibility for the validity or effect of an assignment.

Changes to Policy

The Policy may be amended at any time by written agreement between the Policyholder and Us, without the consent of or notice to any other individual. Any Amendment to the Policy must be in writing and be attached to it. The Amendment must bear the signature or a reproduction of the signature of Our President, a Vice President, or Secretary.

Incontestability

We will not use misrepresentations made by a Covered Person in a written application to contest the validity of the insurance with respect to which such statement was made, after such insurance has been in force prior to the contest for a period of two years during the Covered Person's lifetime, unless the misrepresentations are fraudulent. This section

does not prevent Us from using at any time a defense based on:

1. non-payment of Premium; or
2. any other provision of the Policy; or
3. any other defense that is allowed by law.

Errors

You must be properly insured under the Policy. An error or omission by the Policyholder or by Us will not cause You to become Insured. An error or omission by the Policyholder or by Us will not cancel insurance that should continue nor continue insurance that should end. The requirements of the Policy must be properly met for any change in the amount of Your insurance to take effect. We have the right to full recovery of any overpayments made. Such reimbursement will be required regardless of whether the overpayment occurred due to an error by Us, or by You, or Your representative or the Policyholder.

Legal Actions

No legal action may be brought against Us to recover Policy Benefits until at least 90 days after the required written Notice of Loss is submitted to Us. No such action may be brought more than 3 years after the time written Proof of Loss is required by the Policy to be given or as required by law.

Misrepresentation

Any statement You make in an application to become insured is a representation and not a warranty. No representation made by You in an application to become insured will be used to reduce or deny Your Claim or contest the validity of Your insurance unless:

1. Your insurance would not have been approved except for Your misrepresentation; *and*
2. Your misrepresentation is contained in a written instrument Signed by You; *and*
3. We give You or Your representative a copy of the written instrument that contains Your misrepresentation.

Misstatement of Age or Fact

If a Covered Person's age or any other fact was misstated, We will use the correct facts to determine whether he or she is insured and if so, for what amount and duration. We will adjust Premium rates to the Covered Person's correct age. We may make this change back to the date Coverage became effective based on the misstated information.

Notice to Policyholder

Written notice given by Us to an authorized representative of the Policyholder shall be deemed notice to all affected Covered Persons in the administration of the Policy, including termination of the Policy and termination of individual Coverage under the Policy.

[REPLACEMENT OF EXISTING COVERAGE

This provision applies when the Policy replaces coverage the Policyholder previously obtained through a Prior Plan.

We will give you credit for time periods satisfied or partially satisfied for the Eligibility Waiting Period and Benefit Waiting Period if You were covered under the Prior Plan on the date such Prior Plan terminated.

[In the absence of this provision, a Covered Person who was covered by the Prior Plan at the date of discontinuance might not qualify for coverage under this Policy because the person is [not Actively at Work] [or is confined in a Hospital.]

Each such person will be insured under this Policy if:

1. the person was insured under the Prior Plan, including coverage under the Prior Plan's extension of benefits provision, on the date immediately preceding the date the Policyholder's coverage with the Prior Plan ended;
2. the Prior Plan covered more than [2 -50] Insured Persons; and
3. the person is a member of an Eligible Class under the Policy.

The benefits payable for the persons described above will be the benefits of the Policy less any amount payable under the Prior Plan pursuant to any extension of benefits provision.]]

Nationwide Life Insurance Company

SCHEDULE OF BENEFITS FOR CRITICAL ILLNESS/SPECIFIED DISEASE

This Certificate Schedule of Benefits shows highlights of the coverage available under the Group Policy. Final interpretation of all provisions and benefits will be governed by the Group Policy on file with Nationwide Life Insurance Company at its Administrative Office and with the Policyholder.

Policyholder:	[Group Name]
Policy Effective Date:	[January 1, 2012]
Policy Number:	[111]
[Policyholder Address:	[Address]]
[Policy Anniversary Date:	[January 1]]
[Insured Person:	[name]]
[Certificate Effective Date:	[January 1, 2012]]
[Covered Dependents	[named [Spouse], [Child(ren)], [Domestic Partner]]
Eligible Classes:	[As defined by the Policyholder – insert eligibility requirements here]
[Eligibility Waiting Period:	[If you are in an Eligible Class on or before the Policy Effective Date: [[1-365] [day],[days] [from the first day of Active at Work]] [during an Enrollment Period agreed to by the Policyholder and Us][As defined by the Policyholder]] [If you are entering an Eligible Class after the Policy Effective Date: [[1-365] [day] [days] [from the first day of Active at Work]] [during an Enrollment Period agreed to by the Policyholder and Us][As defined by the Policyholder]]]
[Actively at Work Hours:	[1-40] Hours per week]
[Contribution Type:	[Non-Contributory][Contributory][Voluntary]]
[Initial Enrollment Period:	[10-90] days]
[Enrollment Period:	[January 1, 2013 – February 28, 2013]]
[Method of Premium Payment:	[Remitted by Policyholder to Us or Our Agent] [and/or] [Remitted by You to Us or Our Agent]]
Plan Year:	[Policy Year, Calendar Year]
Benefit Waiting Period:	[0, 30, 60 ,90 days] [and [0, 30, 60, 90] days for cancer]

Covered Critical Illnesses: [Heart Attack] [Stroke] [Coronary Artery By-Pass Graft] [Heart Valve Replacement/Repair] [Coma] [Heart Transplant] [Major Organ Transplant] [End Stage Renal Failure] [Motor Neuron Disease] [Advanced Parkinson's Disease] [Paralysis] [Blindness] [Advanced Alzheimer's Disease] [Occupational HIV] [Invasive Cancer] [In Situ Cancer] [Severe Burn] [Loss of Limb] [Loss of Independent Living] [Angioplasty] [Aortic Surgery]

[We will provide the Benefits shown. Any change in amount is subject to the **"When will Benefits and/or Rates Change"** provision in the Certificate.]

CRITICAL ILLNESS BENEFIT

Your Benefit Amount [including Guaranteed Issue Benefit Amount]: [$500 - $1,000,000 in $500 increments] ~*or*~ [[$500] – [$1,000,000] in [$500] increments as applied for by You and approved by Us.]

[Guaranteed Issue Benefit Amount for You: [$0-$25,000 in $500 increments] ~or~

[Age at Enrollment	
[Less than [60]	[$0 - $25,000 in $500 increments]]
[Age [60] to [69]	[$0 - $25,000 in $500 increments]]
[Age [70] or over	[$0 - $25,000 in $500 increments]]]

[Covered Spouse [or Domestic Partner] Benefit Amount [including Guaranteed Issue Benefit Amount]: [[20%-100%] of Your Benefit Amount [up to [$500-$150,000 in $500 increments]]] ~*or*~ [$500-$150,000 in $500 increments] ~*or*~ [[$500] – [$1,000,000] in [$500] increments as applied for by You and approved by Us.]]

[The Benefit Amount for Your Covered Spouse [or Domestic Partner] may not exceed [20%-75%] of Your Benefit Amount then in force.]

[Guaranteed Issue Benefit Amount for [Spouse] [or Domestic Partner]: [$0-$25,000] ~or~

[Age at Enrollment	
[Less than [60]	[$0 - $25,000 in $500 increments]]
[Age [60] to [69]	[$0 - $25,000 in $500 increments]]
[Age [70] or over	[$0 - $25,000 in $500 increments]]]

[Covered Child(ren) Benefit Amount [including Guaranteed Issue Benefit Amount]: [[10%-75%] of Your Benefit Amount up to [$500-$150,000 in $500 increments]] ~*or*~ [$500-$150,000 in $500 increments] ~*or*~ [[$500] – [$1,000,000] in [$500] increments as applied for by You and approved by Us.]]

[The Benefit Amount for Your Covered Child(ren) may not exceed [10%-75%] of Your Benefit Amount then in force.]

[Guaranteed Issue Benefit Amount for Children: [$0-$25,000]

[Per Person Lifetime Benefit Maximum Payout: [100%, 150%, 200%, 250%, 300%] of Your [or Your Covered Dependents] Benefit Amount shown above for all occurrences combined for all Critical Illnesses.]

CRITICAL ILLNESS MAXIMUMS

We pay this benefit if the Covered Person is Diagnosed with or undergoes a Procedure for the following:

Category	Specified Critical Illness	[First Occurrence] Percent of the Benefit Amount	[Recurrence Benefits Maximum Number and Percent of Benefit]		[Per Category Maximum Total Percent of Benefit]
[1]	[Heart Attack]	[0%-100%]	[0,1]	[25%, 50%, 75%, 100%]	[100%, 125%, 150%, 175%, 200%]
[1]	[Stroke]	[0%-100%]	[0,1]	[25%, 50%, 75%, 100%]	
[1]	[Heart Transplant]	[0%-100%]	[0,1]	[25%, 50%, 75%, 100%]	
[1]	[Coronary Artery By-Pass Graft]	[0%-25%]	Not Covered	Not Covered	
[1]	[Heart Valve Replacement/ Repair]	[0%-25%]	Not Covered	Not Covered	
[1]	[Angioplasty]	[0%-25%]	Not Covered	Not Covered	
[1]	[Aortic Surgery]	[0%-25%]	Not Covered	Not Covered	
[2]	[Major Organ Transplant]	[0%-100%]	[Not Covered][0, 1]	[Not Covered] [25%, 50%, 75%, 100%]	
[2]	[End Stage Renal Failure]	[0%-100%]	[Not Covered][0, 1]	[Not Covered][25%, 50%, 75%, 100%]	
[2]	[Paralysis]	[0%-100%]	Not Covered	Not Covered	

[2]	[Blindness]	[0%-100%]	Not Covered	Not Covered	[100%, 125%, 150%, 175%, 200%]
[2]	[Occupational HIV]	[0%-100%]	Not Covered	Not Covered]	
[2]	[Advanced Alzheimer's Disease]	[0%-100%]	Not Covered	Not Covered	
[2]	[Coma]	[0%-100%]	Not Covered	Not Covered	
[2]	[Motor Neuron Disease]	[0%-100%]	Not Covered	Not Covered	
[2]	[Advanced Parkinson's Disease]	[0%-100%]	Not Covered	Not Covered	
[2]	[Severe Burn]	[0%-100%]	Not Covered	Not Covered	
[2]	[Loss of Limb]	[50% for one dismemberment; 100% for two dismemberments]	Not Covered	Not Covered	
[2]	[Loss of Independent Living]	[0%-100%]	Not Covered	Not Covered	
[3]	[Invasive Cancer]	[0%-100%]	[0,1]	[25%, 50%, 75%, 100%]	[100%, 125%, 150%, 175%, 200%]
[3]	[In-Situ Cancer]	[0%-25%]	[0,1]	[25%, 50%, 75%, 100%]	

[Benefit Waiting Period Reduction:

Reduced Benefit during Benefit Waiting Period: [5%-25%] of Benefit otherwise payable]

[**Survival Period Reduction:**

Reduced Benefit during Survival Period [5%-25%] of Benefit otherwise payable.]

Additional Benefits

[At-Home Recovery Benefit for Invasive Cancer:

Benefit Waiting Period	[0-30] days
Daily Benefit Amount	[$50-$250 in $10 increments] for each day that a Covered Person was Hospital confined as an Inpatient
Maximum Payment Period	[30-365 days]

[This Benefit terminates upon attainment of age [60,65,70,75].]]

[Child Care Reimbursement Benefit: Benefit payable is the lowest of the following amounts:

1. [The amount of childcare expenses actually incurred;
2. [[$100-$2,000] per month per Child;]
3. [[$100-$20,000] for all months and all Covered Dependent Children.]

Maximum Benefit Period: [1-60] month[s] from the Date of Diagnosis

[If You have no eligible children, We will pay a lump sum benefit of: [$100-$1,000]

[This Benefit terminates upon attainment of age [60,65,70,75].]]

[Loss of Independent Living Benefit: [$1,000-$5,000] [This Benefit terminates upon attainment of age [60,65,70,75].]]

[Skilled Nursing Facility Confinement Benefit

Daily Skilled Nursing Facility Confinement Benefit: [$10-$500 in $10 increments] for each day of Skilled Nursing Facility Confinement

Maximum Payment Period during a Period of Confinement for Critical Illness: [90-365 days]

[This Benefit terminates upon attainment of age [60,65,70,75].]]

[Wellness Benefit: [$25, $50, $75, $100, $125] [This Benefit terminates upon attainment of age [60,65,70,75].]]

[AGE REDUCTIONS

[Your Benefit Amount [, and the Benefit Amount for Your Dependent Spouse] [or Domestic Partner] shall reduce as follows: [[The][Each] reduction shall be based upon [the Benefit Amount prior to age [50-99, 1 year increments]][the reduced Benefit amount].] [Benefits will be reduced to a percentage of the amount of insurance calculated in accordance with the table below.] [Such person's Benefit Amount will be reduced to the amount shown.]

Age	*[% of Coverage Reduction]*	*[Benefit %]*	*[Benefit Amount]*
[Age [50-99], 1 year increments]	[0%-100%, 1% increments]]	[0%-100%, 1% increments]]	[$0-$100,000, increments of $100]]
[Age [50-99], 1 year increments]	[0%-100%, 1% increments]]	[0%-100%, 1% increments]]	[$0-$100,000, increments of [$100]]
[Age [50-99], 1 year increments]	[0%-100%, 1% increments]]	[0%-100%, 1% increments]]	[$0-$100,000, increments of [$100]]
[Age [50-99], 1 year increments]	[0%-100%, 1% increments]]	[0%-100%, 1% increments]]	[$0-$100,000, increments of $100]]
[After [50-99, 1 year increments]	[0%-100%, 1% increments]]	[0%-100%, 1% increments]]	[$0-$100,000, increments of $100]]
[After [50-99, 1 year increments]	[0%-100%, 1% increments]]	[0%-100%, 1% increments]]	[$0-$100,000, increments of $100]]]

[Insurance then reduces by an additional [1%-100%, increments of 1%] of the original amount [each subsequent year] [every [2,3,5 years]], until it equals [1%-100%, increments of 1%] of the original amount of insurance.]

[Your Benefit Amount [and the Benefit Amount for Your Spouse [or Domestic Partner]] reduces [immediately upon][on the first of the month following][on the Policy Anniversary which occurs on or next follows] Your attainment of age [50-99, 1 year increments]]. [Your Spouse's [or Domestic Partner's] Benefit Amount reduces [immediately upon][on the first of the month following][on the Policy Anniversary which occurs on or next follows] Your Spouse's [or Domestic Partner's] attainment of age [50-99, 1 year increments].] [Coverage for Your Spouse [or Domestic Partner] will terminate [on the date] [the last day of the month] when [You] attain][Your Spouse [or Domestic Partner] attain[s]] age [50-99, 1 year increments].]

[Any reduction in the amount of Benefits will be made if You are Actively at Work or not.]]

Nationwide Life Insurance Company

Home Office: Columbus, Ohio

On Your Side®

[Nationwide [Specialty] [Employee] Benefits]
[POLICYHOLDER][EMPLOYER] APPLICATION

Application is hereby made for the Benefits set forth herein. The information given below shall be the basis of the agreement with the Plan Sponsor.

Section I - Administrative Information

Company Name				
DBA Name				
Policyholder Street Address (No P.O. Box)	City	State	Zip	County
Mailing Address (if different from above)	City	State	Zip	County

Phone ( )	Administrative Contact
Fax ( )	Title
Employer's Tax Identification Number	Email Address
Requested Effective (MM/[DD][01]/YYYY)	Business Start Date

Describe the Nature of Business	SIC Code

[Will any of the selected coverage types be a takeover for an existing [group] coverage? ☐ Yes ☐ No

If yes, please specify coverage types_____ Effective date of prior coverage types_____

Prior Carrier Name_____ Termination date of prior coverage types_____]

[List names and addresses of all affiliates, branches or subsidiaries on a separate sheet of paper and submit with this application.

Billing Arrangements: Are there multiple units/locations to be billed separately?

☐ Yes ☐ No If "Yes", Number of units_____ ☐ Bill to Individual Units ☐ Bill to Plan Sponsor]

Section II - Eligibility Requirements

1. [In order to apply for this coverage, your company must have minimum of [51] total [eligible] employees.] [Total number of [eligible] employees_____]
2. [[Eligible full-time employees must work at least [X] hours per week, must be actively at work, and must satisfy any applicable waiting period.]] [Total number of [eligible] full-time employees_____.]]
3. [Are part-time employees eligible? ☐ Yes ☐No]
   [If yes, eligible part-time employees must work at least [X] hours per week, must be actively at work, and must satisfy any applicable waiting period.]] [[Total number of [eligible] part-time employees_____]
4. [Total number of COBRA participants_____]
5. [Total number of retirees_____]
6. [Do these eligibility requirements vary by the type of coverage being offered? ☐ Yes ☐ No
   If yes, please provide detail:_____]

[Note: Seasonal employees, contractors, employees of employee leasing firms or employees of professional employee organizations are not eligible.]

7. [Waiting Period ☐ Yes ☐ No If "Yes", Number of days ☐ 0 ☐ 30 ☐ 60 ☐90 ☐ Other_____
   [Waiting Period applies to:
   [☐ Employees hired after the effective date]
   [☐ All Employees (including those hired prior to the effective date]
   [Do different classes have a different waiting period? ☐ Yes ☐ No
   If yes, please describe:]_____]

[Note: New hires will be effective on the first of the month following completion of the waiting period.]

Section III – Product Selection

Please indicate the benefits you have selected.

☐ [Product Name]	☐ [Product Name]	☐ [Product Name]
☐ [Product Name]	☐ [Product Name]	☐ [Product Name]
☐ [Product Name]	☐ [Product Name]	☐ [Product Name]

Section IV – Contributions

[Employer] [Policyholder] contribution percentage:

[[Product Name]_____%]	[[Product Name]_____%]	[[Product Name]_____%]
[[Product Name]_____%]	[[Product Name]_____%]	[[Product Name]_____%]
[[Product Name]_____%]	[[Product Name]_____%]	[[Product Name]_____%]]

Section V - General Conditions

In applying for the Benefits set forth herein, the undersigned understands and agrees that:

1. [Payment of the first premium by the policyholder after delivery of the Policy by us shall constitute acceptance of the terms and conditions contained in the Policy so issued.]
2. [All necessary administrative information concerning all Covered Persons shall be subject to the provisions of the Policy and shall be furnished to us by the Policyholder.]
3. [This Application is subject to the approval of Nationwide Life Insurance Company at its Home Office and that nothing contained herein shall be binding upon said Company until this Application has been so approved.]
4. [All benefits will be in accordance with the benefits proposed and agreed upon between Nationwide Life Insurance Company and the Policyholder as set forth in the Policy, subject to the Policyholder's approval.]
5. [Benefits are not provided unless otherwise provided in the Policy; (a) in case of bodily injury or sickness arising out of or in the course of any employment for wage or profit; or (b) for any bodily injury or sickness for which the person on whom the claim is presented has or had a right to compensation under Workers' Compensation or similar occupational disease law. [(Not applicable to Long Term Disability.)]]

Policyholder (herein referred to as "We") responsibilities under this policy

We agree (1) to maintain the records necessary to the administration of the Policy(s); (2) to report additions, changes, terminations and other information necessary to the administration of the Policy(s) to the insurer within 31 days after the Effective Date of such additions, changes and terminations; (3) that if we do not notify the insurer of any insured ineligibility or termination within [31] days, we shall forfeit any premium refund/credit that would otherwise have been due; (4) to make all such records, including payroll records, tax returns, and personnel files and other documentation as determined by the insurer available upon request to the insurer or its authorized representative; (5) to notify the insurer of claims within [20] days after they are incurred; (6) to pay all premiums in accordance with the terms of this Policy; and (7) to notify all Employees of any termination or rescission of coverage which affects them and refund the appropriate premium.]

By the signature below of its duly authorized representative, the proposed Policyholder hereby applies for the Nationwide Life Insurance Company Policy and the proposed Policyholder understands and agrees that it shall be subject to the provisions set forth herein.

It is understood that all of the answers We have provided are representations and not warranties.

BEFORE SIGNING THE APPLICATION, PLEASE READ THE FRAUD WARNING(S) APPLICABLE TO YOUR STATE(S) BELOW AND CONTINUED ON THE NEXT PAGE.

[(California) For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.]

[(District of Columbia) It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.]

[(Florida) Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.]

[(Kansas) Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, may be guilty of insurance fraud as determined by a court of law.]

[(Kentucky) Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.]

[(**Louisiana**) It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

[(Maine)/(New Mexico)/(Pennsylvania) Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties.]

[(Maryland) Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[(Missouri) An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether an insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question(s) appears in this application, you should not renew it.]

[(NAIC) Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[(New Hampshire) The policy provides limited benefits. Review your policy carefully.]

[(New York) Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.]

[(Oregon) Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be guilty of a fraudulent insurance act, which may result in a conviction of crime.]

[(Puerto Rico) Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a maximum of two (2) years.]

[(Virginia) Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.]

[(Washington) Any person who knowingly provides false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.]

[(All Other States) Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties.]

Please Sign and Date

Dated at_____this_____day of_____,_____/___/____
City and State Date Month Year

By_____ _____ _____
Signature of Employer Printed name of Employer Job Title

[Employer's Signature witnessed by (must be 18 or older):

Signature of Witness	Printed name of Witness	Date]

[Signature of Agent/Producer:]

Signature of Agent/Producer	Printed name of Agent/Producer	Date]

Section IV - Producer Information

Company/Brokerage Name		
Company Address (if different than above) City, State Zip		
Name of Agent Representing this Group		
Phone ( ) -	Fax ( ) -	Email Address
Producer Number		

Send Completed Application to:
[Nationwide Specialty Insurance [WorkPlace] Benefits[SM], PO Box 1199, Newark, OH 43058-1199]

Nationwide Life Insurance Company

Home Office: Columbus, Ohio

[Policyholder,Participating Organization] Application

On Your Side®

(Print or type only)

1. Policyholder Information

Policyholder Name			[Previous] Policy Number	
Location Address	City	State	Zip	County
[Mailing Address (if different from above)	City	State	Zip	County]
[Phone] ( )	[Administrative Contact]			
[Fax] ( )	[Title]			
Requested Effective Date (MM/DD/YYYY)	[Email Address]			

2. [Participating Organization Information]

Participating Organization Name			[Previous Policy Number]	
Location Address	City	State	Zip	County
Mailing Address (if different from above)	City	State	Zip	County
Phone ( )	Administrative Contact			
Fax ( )	Title			
Requested Effective Date (MM/DD/YYYY)	Email Address			

3. [Lifestyle Question]

Within the next 12 months, do You intend to travel or reside outside Canada or the United States for more than a month? If yes, please provide details including where, when, why and for how long You intend to travel: _____ _____	☐Yes ☐No

4. General Conditions

In applying for the Benefits set forth herein, the undersigned understands and agrees that:

1. All necessary administrative information concerning all Insured Persons shall be subject to the provisions of the Policy and shall be maintained by the [Policyholder, Participating Organization].
2. This Application is subject to the approval of Nationwide Life Insurance Company at its Home Office and that nothing contained herein shall be binding upon said Company until this Application has been so approved.
3. All benefits will be in accordance with the benefits proposed and agreed upon between Nationwide Life Insurance Company and the Policyholder as set forth in the Policy, subject to the Policyholder's approval.
4. Benefits are not provided unless otherwise provided in the Policy; (a) in case of bodily injury or sickness arising out of or in the course of any employment for wage or profit; or (b) for any bodily injury or sickness for which the person on whom the claim is presented has or had a right to compensation under Workers' Compensation or similar occupational disease law.

By the signature below of its duly authorized representative, the proposed Policyholder hereby applies for the Nationwide Life Insurance Company Policy and the proposed Policyholder understands and agrees that it shall be subject to the provisions set forth herein.

It is understood that all the answers We have provided are representations and not warranties.

[Participating Organization Agreement

The Participating Organization understands that the insurance coverages will only be as provided for under the Policy issued to [the Trustee as] the Policyholder. It is further understood and agreed that unless and until otherwise changed, all premiums payable on account of insurance under the Policy shall be paid solely from contributions from Insured persons, to be billed directly to such persons by Nationwide Life Insurance Company or its administrator. The undersigned acknowledges that the [Trustee] [Policyholder] is not an insurer, and has no obligation regarding payment of premiums or handling of claims for the insurance provided under the Policy. The [trust agreement and the] Policy issued to the [Trust] [Policyholder] are available for examination by the Participating Organization at the office of the Administrator, {insert address here}.]

State Fraud Notices

[(California) For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.]

[(District of Columbia) It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.]

[(Florida) Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.]

[(Kansas) Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, may be guilty of insurance fraud as determined by a court of law.]

[(Kentucky) Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.]

[(**Louisiana**) It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

[(Maine)/(New Mexico)/(Pennsylvania) Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties.]

[(Maryland) Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[(Missouri) An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether an insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question(s) appears in this application, you should not renew it.]

[(NAIC) Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[(New Hampshire) The policy provides limited benefits. Review your policy carefully.]

[(New York) Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a

fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.]

[(Oregon) Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be guilty of a fraudulent insurance act, which may result in a conviction of crime.]

[(Puerto Rico) Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a maximum of two (2) years.]

[(Virginia) Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.]

[(Washington) Any person who knowingly provides false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.]

[(All Other States) Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties.]

Please Sign & Date

By signing below, you agree that you have read all of the General Conditions provided with this application.	
Agent's Signature	Signature of Applicant
Agent's Printed Name and Number	Printed Name of Applicant and Title
Agent's Phone Number	Applicant's Phone Number
Agent's E-mail Address	Applicant's E-mail Address

Nationwide Life Insurance Company

Home Office: Columbus, Ohio

On Your Side®

Evidence of Insurability Form

Section I –[Employer][Policyholder] Information (Please print in ink or type)

Group Number [Employer][Policyholder] Name	
[Employee][Member] Name/Member#	Class
[Employer][Policyholder] Address	City State Zip Code

Section II – [Employee][Member] Information

Last Name, Suffix (e.g., Sr., Jr.)	First Name	M/I	State of Birth	Date of Birth (MM/DD/YYYY)
Residence Address	City		State	Zip Code
Home Phone #	Work Phone #			
Gender (M/F)	Marital Status ☐Single ☐Married ☐Divorced/Separated	[Social Security #]	Height (feet' & inches")	Weight (lbs)
[Occupation or Job Title]	[Employee Annual Earnings $]		[Hire Date (MM/DD/YYYY)]	

Amount of Coverage Requested:	[Current Amount: (if applicable)]	Requested Amount:	Reason for request:		
[Product Name]	[$_____]	[$_____]	[i.New member applying for coverage	☐Yes	☐No]
[Product Name]	[$_____]	[$_____]	[ii.Coverage requested above guarantee issue limit	☐Yes	☐No]
[Product Name]	[$_____]	[$_____]	[iii.Late Enrollee	☐Yes	☐No]
[Product Name]	[$_____]	[$_____]	[iv.Change in Family Status	☐Yes	☐No]
			[v. Annual Enrollment	☐Yes	☐No]

Section III – Dependent Information

Relation	Last Name, First, MI (Suffix, e.g., Sr,Jr)	[Social Security#] (XXX-XX-XXXX)	Date of Birth (MM/DD/YYYY)	Height (' ")	Weight (lbs)	State of Birth	Gender (M/F)	Full-Time Student	Eligible Income Tax Exemption
Spouse [*]					lbs				
Child					lbs			☐Yes ☐No	☐Yes ☐No
Child					lbs			☐Yes ☐No	☐Yes ☐No
Child					lbs			☐Yes ☐No	☐Yes ☐No
Child					lbs			☐Yes ☐No	☐Yes ☐No

To name additional dependents, please attach a separate sheet.

[*For purposes of this form, Spouse includes a Domestic Partner [or civil union partner]]

Section IV – Medical Questionnaire

COMPLETE THE FOLLOWING MEDICAL QUESTIONS FOR ALL PERSONS TO BE COVERED: For the purpose of the following medical questions, the term "medical or social practitioner" includes but is not limited to: a doctor, nurse, psychologist, psychiatrist, social worker, chiropractor, podiatrist, therapist, pathologist, dentist, optometrist, osteopath, clergy, Christian Science practitioner, or any person affiliated with a self-help program such as Alcoholics Anonymous, a substance abuse program, or a weight loss program.

[Part [1]]
[*~ to be completed when applying for Life, Disability and Critical Illness coverage ~ this section may be deleted if coverage is only for Critical Illness ~*

Have you or any of your dependents smoked or used tobacco in the past 5 years? ☐ Yes ☐ No

If yes, who and when? _____ Type(s)? _____

In the past [[2,5,7,10] years], has anyone ever:

a.	Had high blood pressure or high cholesterol?	☐ Yes ☐ No
b.	Had heart disease, cancer, diabetes, arthritis, or asthma?	☐ Yes ☐ No
c.	Had epilepsy?	☐ Yes ☐ No
d.	Had back or spinal disorders?	☐ Yes ☐ No
e.	Had a disorder of the stomach, intestines, liver, gallbladder or rectum (gastrointestinal disorder)?	☐ Yes ☐ No
f.	Had a disorder of the kidney, bladder, prostrate or reproductive organs (genito-urinary disorder)?	☐ Yes ☐ No
g.	Had a respiratory or lung disorder?	☐ Yes ☐ No
h.	Had a stroke or transient ischemic attack (TIA)?	☐ Yes ☐ No
i.	Had counseling by a medical or social practitioner for an emotional, mental or nervous condition?	☐ Yes ☐ No
j.	Had counseling or been treated for alcohol or chemical dependency, or been convicted of driving under the influence of alcohol or drugs?	☐ Yes ☐ No
k.	Had Fibromyalgia, a muscular condition, or a sleep disorder?	☐ Yes ☐ No

[Has anyone ever been diagnosed by, or received treatment from, a medical or social practitioner for Acquired Immune Deficiency Syndrome (AIDS) or AIDS- Related Complex (ARC), or tested positive for antibodies to the Human Immunodeficiency Virus (HIV)?]] ☐ Yes ☐ No

[In the past [2, 3, 4, 5] years, has anyone been informed by a medical or social practitioner of any irregular test results not found to be normal or benign on further testing or advised to have any diagnostic/screening tests or procedures which have not yet been completed?] ☐ Yes ☐ No

[Part [2]]
[[If you are applying for [Life][, Short Term Disability] [or] [Long Term Disability] coverage, You are also required to answer the following questions:]

In the past [[2, 3] years], has anyone been engaged in or does anyone contemplate being engaged in any potentially hazardous sports or hobbies such as aviation, scuba diving, bungee jumping, mountain climbing, sky diving, motor racing, or similar activities? ☐ Yes ☐ No

Has anyone ever received pension or worker's compensation benefits or other payment because of an injury, sickness or disability? ☐ Yes ☐ No]

[Part [3]]
[[If you are applying for Critical Illness, You are also required to answer the following questions:] ~ *this section will be included for Critical Illness ~*

	[Member][EE]	**[SP]**	**[CH]**
[Have you or any of your dependents smoked or used tobacco in any form in the past 12 months? If yes, who and when? _____ Type(s)? _____]	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Is any person now being treated for, or [ever][in the past [2,5,7, 10] years]	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

been treated for or been told by a medical practitioner that he or she has suffered a [stroke or transient ischemic attack,] heart attack, heart condition or abnormality, any artery disease or peripheral vascular disease?

Is any person currently undergoing any diagnostic test for, now being treated for or [ever] [in the past [2, 5, 7, 10] years] been treated for or been told by a medical practitioner that he or she has:

[Cancer (except basal cell cancer), or any malignancy including carcinoma, Hodgkin's disease, leukemia, lymphoma, or any malignant tumor?]	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
[A disorder of the central nervous system, Parkinson's disease, Amyotrophic Lateral Sclerosis (Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy?]	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
[[Diabetes], Hepatitis (except Hepatitis A), pancreatitis, intestinal bleeding, Crohn's disease, liver disease or chronic kidney disease?]	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
[Alzheimer's, Senility, Dementia or organic brain disease?]	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
[Emphysema, asthma, or Chronic Obstructive Pulmonary Disease (COPD)?]	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
[Glaucoma, retinitis pigmentosa, Macular Degeneration, or optic neuritis?]	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
[Emotional, mental or nervous illness?]	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
[Multiple Sclerosis, systemic lupus, sarcoidosis, rheumatoid arthritis, autoimmune or connective tissue disease or disorder.]	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
[Is any person currently undergoing any diagnostic test for, now being treated for or [ever] [in the past [2, 5, 7, 10] years] been treated for a spinal cord injury, spinal stenosis or paralysis?]	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
[Does any person currently have uncontrolled hypertension, uncontrolled high blood pressure or uncontrolled high cholesterol?]	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
[Has anyone ever been diagnosed by, or received treatment from, a medical or social practitioner for Acquired Immune Deficiency Syndrome (AIDS) or AIDS- Related Complex (ARC), or tested positive for antibodies to the Human Immunodeficiency Virus (HIV)?]	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
[Does any person currently have or [ever][in the past [2, 5, 7, 10] years] been diagnosed with, or treated for precancerous lesions/tumors, fibrocystic breast disease, polyps, abnormal moles or lesions, dysplastic nevi, or skin cancer?]	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
[[Has any] [Have 2 or more] immediate family member[s](whether living or dead) of any of the Persons to be Covered ever suffered from, or [is/are] currently suffering from: cancer, heart disease, stroke, chronic kidney disease, diabetes, ALS (amyotrophic lateral sclerosis or Lou Gehrig's disease), motor neuron disease, Alzheimer's disease, Parkinson's disease or any other hereditary disease prior to age [55, 60, 65]?]	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
[In the past [2, 3, 4, 5] years, has anyone been informed by a medical or social practitioner of any irregular test results not found to be normal or benign on further testing or advised to have any diagnostic/screening tests or procedures which have not yet been completed?]]	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

[Part [4]]
[[If you are applying for [Life][, Short Term Disability] [or] [Long Term Disability] coverage, You are also required to answer the following questions:]

[Additional Evidence of Insurability]

[In the past [2, 3, 4, 5] years, has anyone been informed by a medical or social practitioner of any irregular test results not found to be normal or benign on further testing or advised to have any diagnostic/screening tests or procedures which have not yet been completed?] ☐Yes ☐No

[In the past [2, 5, 7, 10] years, has anyone ever had an inpatient admission and/or outpatient surgery?] ☐Yes ☐No

[In the past [2, 3, 4, 5] years, has anyone been regularly taking any prescribed medication?] ☐Yes ☐No

[In the past 5 years, has anyone contemplated an operation or doctor visit for an existing injury or ailment?] ☐Yes ☐No

[During the past 3 years, has anyone sought medical treatment, or been advised by a medical or social practitioner to seek treatment, for any condition not stated above?] ☐Yes ☐No

[Has anyone ever been rated or declined for, or refused reinstatement or renewal of, critical illness insurance? ☐Yes ☐No

If yes, name of person, date and reason:_____]

[In the past 12 months, has anyone been absent from work for more than 10 consecutive days due to illness or injury?] ☐Yes ☐No]

[Part[5]]
If you [are applying for [Life][, Short Term Disability] [or] [Long Term Disability] and you] answered YES to any question, please provide details below if you haven't already done so. If additional space is needed, please attach a separate page including your signature and date.

Question #	Name of Individual	Name of Illness or Injury	Dates of Treatment	Any Remaining Effects?	Name of Medication and Dosage	Name and Address of Physician / Hospital

]

AGREEMENT AND AUTHORIZATION

I understand that, in order for Nationwide Life Insurance Company or any of its subsidiaries or affiliates to accept or decline this application, all of the information requested on the application must be completed. In the event that I have not correctly or fully completed this application, my signature shall authorize Nationwide Life or any of its subsidiaries or affiliates to obtain the necessary information for me and to complete that information on this application. I realize that Nationwide Life or any of its subsidiaries or affiliates reserves the right to accept or decline this application (or to accept only certain persons for coverage) and that no right whatsoever is created by this application.

For the purpose of evaluating my application for insurance, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility; insurance company; the Medical Information Bureau, Inc.; or other organization, institution or person that has any records or knowledge of me, or my health, or of my family for whom this insurance application is made or their health to give Nationwide Life or any of its subsidiaries or affiliates or its reinsurers any such information. I also authorize Nationwide Life or any of its subsidiaries or affiliates or its reinsurers to release any information regarding me or my health, or that of my family for whom insurance application is made, to the Medical Information Bureau, Inc.; or other life insurance companies in which I have policies or to which I may apply; and other insurers to which a claim for benefits may be submitted. I understand that this information will be used by Nationwide Life or any of its subsidiaries or affiliates to determine eligibility for insurance. This information includes information about drugs, alcoholism or mental illness. This authorization will be valid from the date signed for a period of twenty four months. A photocopy of this authorization will be as valid as the original. I understand that I may request a photocopy.

I certify that I have read, or have had read to me, the completed application and that all information is true and complete to the best of my knowledge. I understand that any misrepresentation or significant omission may void my coverage. I acknowledge that I have received the Fair Credit Reporting Notice.

PLEASE READ THE FRAUD WARNING(S) APPLICABLE TO YOUR STATE(S) BELOW AND CONTINUED ON THE NEXT PAGE.

[(California) For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.]

[(District of Columbia) It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.]

[(Florida) Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.]

[(Kansas) Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, may be guilty of insurance fraud as determined by a court of law.]

[(Kentucky) Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.]

[(**Louisiana**) It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

[(Maine)/(New Mexico)/(Pennsylvania) Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties.]

[(Maryland) Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[(Missouri) An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether an insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question(s) appears in this application, you should not renew it.]

[(NAIC) Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[(New York) Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.]

[(Oregon) Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be guilty of a fraudulent insurance act, which may result in a conviction of crime.]

[(Puerto Rico) Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a maximum of two (2) years.]

[(Virginia) Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.]

[(Washington) Any person who knowingly provides false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.]

[(All Other States) Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties.]

***Includes any adult over age 18 applying for coverage.**

_____

SIGNATURE OF APPLICANT **DATE**

_____

SIGNATURE OF SPOUSE / DOMESTIC PARTNER (if applicable) **DATE**

Nationwide Life Insurance Company

INVESTIGATIVE CONSUMER REPORTS

To provide insurance coverage, we need to obtain information about you and any other persons proposed for insurance. Some of that information will come from you and some will come from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information that is related to a claim or a civil or criminal proceeding.

If we use an independent reporting agency for a report, you have the right to be personally interviewed by them. If you wish to be interviewed, please tell us how the agency can contact you and every effort will be made to interview you. Even if you are not interviewed, you have the further right to request that the reporting agency provide you with a copy of the report it makes. Write us at the address shown below and we'll give you the name and address of any agency we have used to prepare a report on you so that you can contact them directly to find out more about that report.

If you want a more detailed explanation of our information practices, please write to us at:

Nationwide Life Insurance Company
[P.O. Box 2399
Columbus, Ohio 43216]

This notice is to inform you that as part of our normal underwriting procedures in connection with an application for insurance:

A. An investigative consumer report may be made whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. This inquiry will include information as to character, general reputation, personal characteristics and mode of living, with respect to you, members of your family and other having an interest in or closely connected with the insurance transaction; and

B. Upon your written request, made within a reasonable time after you receive this notice, additional information as to the nature and scope of the investigation, if one is made, will be provided. Request for additional information should be directed to the same address as shown above, under NOTICE OF INSURANCE PRACTICES.

IMPORTANT NOTICE

The underwriting process is necessary to assure reasonable cost of insurance and provide a mechanism by which policyholders pay their fair share of the cost. In considering your application, information from various sources is considered, including statements in the application and any reports we obtain from doctors or medical facilities where you have been attended.

Information regarding your insurability will be treated as confidential. Nationwide Life Insurance Company or its reinsurers may, however, make a brief report to the Medical Information Bureau, a nonprofit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life, disability or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its files.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is:

[
50 Braintree Hill Park, Suite 400
Braintree, Massachusetts 02184-8734
Telephone number (866) 692-6901
TYY (866) 346-3642 (for hearing imparted).

Nationwide Life Insurance Company, or its reinsurers, may also release information in our file to other life insurance companies to whom you may apply for life, disability or health insurance, or to whom a claim for benefits may be submitted.

Be sure to keep a copy of this form and all additional documentation for your records.

Nationwide Life Insurance Company
Columbus, Ohio

AMENDMENT NUMBER [1]

This amendment forms a part of the Plan to which it is attached and amends such Plan in the manner indicated for Arkansas residents only. Anything specifically stated in this amendment overrides anything to the contrary in the Plan, and will be subject to all other parts of the Plan.

1. Under the section entitled **WHEN COVERAGE BEGINS AND ENDS**, the last two paragraphs of the provision entitled **When will Coverage begin for Your Dependents?** are deleted in their entirety and replaced with the following:

Newborn Children: The Enrollment Form must be completed prior to the expected birth of a child. If You did not elect Dependent's Coverage before the birth of a child, Coverage on that child will not be denied, with respect to Critical Illness Insurance if You notify Us in writing of the birth of such child and [authorize the Policyholder to make the required payroll deductions][make any premium payment due] toward the cost of Dependents Coverage, within 30 days of the date of birth. If You already have Dependent Coverage for one Dependent, Coverage for a newborn will be added without Proof of Insurability. However, We require You to notify Us of additional Dependents [within 30 days of the date of birth or Placement for Adoption] to assure accurate claims handling.

Adopted Children: The coverage required by this section shall begin on the date of the filing of a petition for adoption if You complete the Enrollment Form within sixty (60) days after the filing of the petition for adoption [and [authorize the Policyholder to make the required payroll deductions][make any premium payment due] toward the cost of Dependents Coverage]. However, the coverage required by this section shall begin from the moment of birth if the petition for adoption and the Enrollment Form are filed within sixty (60) days after the birth of the minor. If You already have Dependent Coverage for one Dependent, Coverage for a newly acquired child Placed for Adoption, will be added without Proof of Insurability. However, We require You to notify Us of additional Dependents [within 60 days of the date of Placement for Adoption] to assure accurate claims handling.

[The Policyholder may require employees to contribute toward the cost of all or part of their Dependent insurance. If so, the only Eligible Dependent who may become insured before You agree to those contributions are as described above. The form for this agreement may be obtained from the Policyholder. [If You [Sign the form] more than [31-90] days after You became eligible for Dependent insurance, the insurance for each Eligible Dependent will be deferred until the date We approve Proof of Insurability for each Eligible Dependent as described above.]

2. Under the section entitled **WHEN COVERAGE BEGINS AND ENDS**, the paragraph entitled **When will Coverage end?** in the paragraph with the Handicapped Dependent Children provision, the timeline for proof of incapacity is removed in its entirety as follows:
[Handicapped Dependent Children: Insurance will continue for a handicapped child who has attained the limiting age for Eligible Dependents, if such child is unwed and mentally or physically incapable of earning their own living; and dependent on You for support and maintenance and was covered on the day immediately prior to attaining the limiting age. Proof of incapacity must be furnished to Us upon attainment of the limiting age.]]

3. Under the **Pre-Existing Conditions Limitation** provision, the paragraph entitled **What is a Pre-existing Condition and how does it affect the Benefits?** is deleted in its entirety and replaced with the following:

What is a Pre-existing Condition and how does it affect the Benefits?

A Pre-existing Condition is any condition [(a) that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the [3,6] months immediately prior to a Covered Person's Effective Date;] or [[(b)] for which medical advice, diagnosis, care or treatment was recommended or received within [3,6] months immediately prior to a Covered Person's Effective Date;]] The [3,6] month period is called a look back period.

Benefits are not provided for a Diagnosis made or Procedure recommended for a Pre-existing Condition under the Policy.

A condition will no longer be considered a Pre-existing Condition for any Covered Person [who is not a late enrollee per the "When do You enroll" provision] after such person has been covered for [6, 12] consecutive months from his or her Effective Date. [If a Covered Person is a late enrollee, a condition will no longer be considered a Pre-existing Condition after a Covered Person has been covered for 12 consecutive months from his or her Effective Date.]

[With respect to a benefit increase, We will not pay benefits for such benefit increase for a Critical Illness that is caused by or results from a Pre-existing Condition if the Critical Illness occurs during the first [6, 12] months after such increase in the Benefit Amount.]]

This amendment is hereby accepted and deemed valid on the effective date of [ ].

Payment of premium on or after the effective date of the Amendment shall constitute acceptance by the Policyholder of the Plan modifications contained herein.

No other Plan provision or condition is changed in any way by this amendment, except as described above.

Signed for Nationwide Life Insurance Company

[ ] [ ]

Secretary President

SERFF Tracking Number:	*NWLC-128237251*	*State:*	*Arkansas*
Filing Company:	*Nationwide Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*GCI AO L20 000 0312*		
TOI:	*H07G Group Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07G.001 Critical Illness*
Product Name:	*Critical Illness - Forms*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	05/09/2012

Comments:
Readability Certificate

Attachment:
Read Cert.pdf

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	05/09/2012

Bypass Reason: Please see Forms tab for Employer and Association Applications

Comments:

CERTIFICATION OF COMPLIANCE WITH
INSURANCE POLICY SIMPLIFICATION REQUIREMENTS

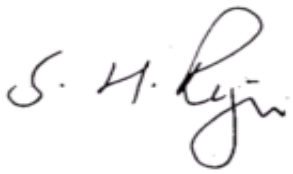
Name and Address of Insurer:

Nationwide Life Insurance Company
Nationwide Specialty Insurance
One Nationwide Plaza
Columbus, Ohio 43215
Mail Code: 1-32-101

Policy/Certificate Form Number(s):

GCI AO L20 000 0312	Group Critical Illness Policy
GCI AO L25 000 0312	Group Critical Illness Certificate
GCI AO L26 000 0312	Group Critical Illness Schedule of Benefits
GGEN AO L23 000 0312	Group Employer Application
AGEN AO L23 000 0312	Group Association Application
GCI AR L24 000 0312	Group Critical Illness State Specific Amendment

I certify that, to the best of my knowledge and belief, the policy/certificate forms are in compliance with the Flesch reading ease score and the other requirements set forth in the Insurance Policy Language Simplification Act of the State of Arkansas.



Syed S. Rizvi
Chief Specialty Insurance Officer

Date: April 6, 2012

SERFF Tracking Number:	*NWLC-128237251*	*State:*	*Arkansas*
Filing Company:	*Nationwide Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*GCI AO L20 000 0312*		
TOI:	*H07G Group Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07G.001 Critical Illness*
Product Name:	*Critical Illness - Forms*		
Project Name/Number:	*/*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
04/22/2012	Form	Endorsement	05/08/2012	AR State Endorsement.pdf (Superceded)

Nationwide Life Insurance Company
Columbus, Ohio

AMENDMENT NUMBER [1]

This amendment forms a part of the Plan to which it is attached and amends such Plan in the manner indicated for Arkansas residents only. Anything specifically stated in this amendment overrides anything to the contrary in the Plan, and will be subject to all other parts of the Plan.

1. Under the section entitled **WHEN COVERAGE BEGINS AND ENDS**, the last two paragraphs of the provision entitled **When will Coverage begin for Your Dependents?** are deleted in their entirety and replaced with the following:

Newborn Children: The Enrollment Form must be completed prior to the expected birth of a child. If You did not elect Dependent's Coverage before the birth of a child, Coverage on that child will not be denied, with respect to Critical Illness Insurance if You notify Us in writing of the birth of such child and [authorize the Policyholder to make the required payroll deductions][make any premium payment due] toward the cost of Dependents Coverage, within 30 days of the date of birth. If You already have Dependent Coverage for one Dependent, Coverage for a newborn will be added without Proof of Insurability. However, We require You to notify Us of additional Dependents [within 30 days of the date of birth or Placement for Adoption] to assure accurate claims handling.

Adopted Children: The coverage required by this section shall begin on the date of the filing of a petition for adoption if You complete the Enrollment Form within sixty (60) days after the filing of the petition for adoption [and [authorize the Policyholder to make the required payroll deductions][make any premium payment due] toward the cost of Dependents Coverage]. However, the coverage required by this section shall begin from the moment of birth if the petition for adoption and the Enrollment Form are filed within sixty (60) days after the birth of the minor. If You already have Dependent Coverage for one Dependent, Coverage for a newly acquired child Placed for Adoption, will be added without Proof of Insurability. However, We require You to notify Us of additional Dependents [within 60 days of the date of Placement for Adoption] to assure accurate claims handling.

[The Policyholder may require employees to contribute toward the cost of all or part of their Dependent insurance. If so, the only Eligible Dependent who may become insured before You agree to those contributions are as described above. The form for this agreement may be obtained from the Policyholder. [If You [Sign the form] more than [31-90] days after You became eligible for Dependent insurance, the insurance for each Eligible Dependent will be deferred until the date We approve Proof of Insurability for each Eligible Dependent as described above.]

3. Under the **Pre-Existing Conditions Limitation** provision, the paragraph entitled **What is a Pre-existing Condition and how does it affect the Benefits?** is deleted in its entirety and replaced with the following:

What is a Pre-existing Condition and how does it affect the Benefits?

A Pre-existing Condition is any condition [(a) that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the [3,6] months immediately prior to a Covered Person's Effective Date;] or [[(b)] for which medical advice, diagnosis, care or treatment was recommended or received within [3,6] months immediately prior to a Covered Person's Effective Date;]] The [3,6] month period is called a look back period.

Benefits are not provided for a Diagnosis made or Procedure recommended for a Pre-existing Condition under the Policy.

A condition will no longer be considered a Pre-existing Condition for any Covered Person [who is not a late enrollee per the "When do You enroll" provision] after such person has been covered for [6, 12] consecutive months from his or her Effective Date. [If a Covered Person is a late enrollee, a condition will no longer be considered a Pre-existing Condition after a Covered Person has been covered for 12 consecutive months from his or her Effective Date.]

[With respect to a benefit increase, We will not pay benefits for such benefit increase for a Critical Illness that is caused by or results from a Pre-existing Condition if the Critical Illness occurs during

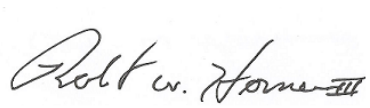
the first [6, 12] months after such increase in the Benefit Amount.]]

This amendment is hereby accepted and deemed valid on the effective date of [ ].

Payment of premium on or after the effective date of the Amendment shall constitute acceptance by the Policyholder of the Plan modifications contained herein.

No other Plan provision or condition is changed in any way by this amendment, except as described above.

Signed for Nationwide Life Insurance Company

[] []

Secretary President